

“You know Georgians, we are each other's
psychologists”:

Mental health care spaces, trajectories,
and social integration among internally
displaced persons in Georgia

By
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DEDICATION

To the internally displaced in Georgia
And to all those, worldwide, who have been forcibly displaced
And seek to find their way home

And to my mother, who has always taught me that:
“This above all: to thine own self be true”

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ABBREVIATIONS

DALY: Disability-Adjusted Life Year

GoG: Government of Georgia

IASC: Inter-Agency Standing Committee

IDMC: Internal Displacement Monitoring Centre

IDP: Internally Displaced Person

IPS: Institute for Policy Studies

MDD: Major Depressive Disorder

MHPSS: Mental Health and Psychosocial Services

MNS: Mental, Neurological, and Substance Use Disorders

MRA: Ministry of Internally Displaced Persons from the Occupied Territories,
Accommodation and Refugees of Georgia

NEM-II: Network Episode Model Phase II

NGO: Non-Governmental Organization

PTSD: Post-Traumatic Stress Disorder

SAMHSA: United States Substance Abuse and Mental Health Services Administration

UNHCR: United Nations High Commissioner for Refugees

US: United States

WHO: World Health Organization

Chapter 1. Introduction

Study Objectives, Aims, and Significance

Mental, neurological and substance use disorders (MNS) constitute a significant proportion of the burden of disease in the developing world (World Health Organization, 2008). Despite growing recognition of this problem in research and policy circles, there is limited understanding of what constitutes appropriate and acceptable treatments of mental illness in various cultural settings (Saraceno, van Ommeren, Batniji, Cohen, Gureje, Mahoney et al., 2007). Care-seeking for mental illness and psychological problems is impeded by a lack of access to formal services and social stigma of mental illness (Link, Yang, Phelan, & Collins, 2004; Sartorius, 2007). In the absence of mental health service utilization, it remains unclear how psychological problems are recognized, what kinds of responses are considered appropriate, and the processes and pathways by which people seek care. A study of mental health care-seeking behavior, management patterns, and social support systems, particularly within the household and informal sector, can help address these gaps.

The study population for this dissertation is internally displaced persons (IDPs) in the country of Georgia (hereafter Georgia) who were displaced as a result of conflicts in the 1990s and 2008. Georgia, a former Soviet Republic in the Southern Caucasus, is a country in political and economic transition that has experienced significant regional conflict and displacement in the past two decades. Georgia's public mental health system is under-developed and relies primarily on institutionalization for serious cases

of mental illness. However, the Government of Georgia (GoG) is currently developing and implementing a series of health system reforms. The GoG's primary strategy for resolving internal displacement within the country is local integration or adaptation to host communities. A key objective of this dissertation is to shed light on existing household and social support structures of care that are activated and utilized in processes of integration and recovery from mental illness. In so doing, it aims to inform policy recommendations and program development in Georgia in terms of both local integration objectives and community mental health interventions. A further objective of this research is to understand the potential of the household, IDP shelter, and informal domain as therapeutic spaces that promote recovery and integration among Georgian IDPs. Another objective is to describe key social, economic, displacement-related, and mental health problems among the Georgian IDP population. Finally, this research aims to explore constructs of identity and processes of becoming, belonging, and community connectedness among urban displaced persons.

The specific research aims and research questions of the three studies that comprise this dissertation are as follows:

Study 1

Primary Research Aim: Describe key community-wide and mental health problems experienced by older adult Georgian IDPs.

Primary Research Questions:

1. What are key community-wide problems that older adult Georgian IDPs have?
2. What are key mental health problems that older adult Georgian IDPs have?

3. What terminology do older adult Georgian IDPs and local key informants use to describe these mental health problems?

Study 2

Primary Research Aim: Describe experiences of social support seeking, perceptions of community belonging, and the process of social integration among long-term Georgian IDPs, as well as linkages among them.

Primary Research Questions:

1. How do long-term Georgian IDPs' perceptions of identity, community belonging and experiences of social integration intersect with social support seeking?
2. How does care-seeking for emotional and social support reflect levels of integration, inter-connectedness, and trust?

Study 3

Primary Research Aim: Describe mental health care-seeking and management decision-making, strategies, and trajectories among long-term Georgian IDPs.

Primary Research Questions:

1. What are decision-making processes and thresholds of disclosure for mental illness and care-seeking among long-term Georgian IDPs?
2. What strategies, services, and treatments do long-term Georgian IDPs utilize when seeking care for, and managing, mental health problems?
3. How are care-seeking pathways and treatments distributed across informal, lay, and formal domains of care?

4. What are mental illness and recovery trajectories among long-term Georgian IDPs?

Background

Mental Health in Low and Middle Income Countries

Increased scholarly and donor attention is being paid to the global burden of mental health and access to mental health services, particularly within low and middle income countries (World Health Organization, 2008). In 2008, the World Health Organization (WHO) instituted the mhGAP (Mental Health Gap Action Programme) to expand its work in treating mental disorders in low and middle income countries. Mental illnesses constitute a significant portion of the global burden of disease, yet continue to be poorly understood in diverse cultural and linguistic settings. In low and middle income countries, particularly in regions beset by armed conflict or political instability, mental health infrastructure is often absent or inadequate (Saraceno et al., 2007). In such settings, mental illnesses can compound existing diseases and contribute to health insecurity and political insecurity. Access to mental health care in low-resource settings is complicated by lack of availability of effective services, under- utilization of services, stigma of psychiatric diagnoses and treatment, and local cultural conceptions of mental health and treatment systems (Lay, Lauber, Nordt & Rossler, 2006; Link, Yang, Phelan, & Collins, 2004; Shin, 2002). In the absence of formal mental health systems, it is important to understand how decisions are made about care-seeking and the management of mental illness symptoms.

In low and middle income countries and low resource settings, advancement of mental health systems has been hampered by a lack of political commitment, financing and budgeting of resources, trained mental health professionals, and social stigma of mental illness. Most countries do not allocate sufficient resources to develop and maintain mental health systems (WHO, 2008). An implicit Maslowian approach to health and well-being among policy-makers and international donors has perhaps also contributed to the identification of mental health as a less urgent need in a 'hierarchy of needs' and program priorities. Increasingly, however, mental illness has been found to be co-morbid with a range of infectious and chronic diseases, for example HIV/AIDS and cardiovascular disease, as well as associated with contextual and social variables such as pregnancy, unemployment, marriage, and type of housing (Artazcoz, Benach, Borrell, & Cortes, 2004; Das, Do, Friedman, McKenzie & Scott, 2008; Evans, Wells, & Moch, 2003; Kasl, 1979; Prince, Patel, Saxena, Maj, Maselko, Phillips et al., 2007; Weich, Blanchard, Prince, Burton, Erens & Sproston, 2002). Instead of focusing on a hierarchy of health needs, the dynamic interplay of different aspects of health should be considered. Proponents of mental health programming in low and middle income countries argue that targeting the mental health of populations is closely linked with targeting impoverishment and facilitating economic security and growth, as well as social reconstruction in post-conflict settings (Patel & Kleinman, 2003; van de Put, 2002; World Health Organization, 2008; World Bank, 2005).

MNS contribute to approximately 30% of the burden of non-communicable diseases, as measured by disability-adjusted life years (DALYs). Furthermore, approximately 76% of the global burden of neuropsychiatric disorder is in low and

middle income countries (World Health Organization, 2008). From 2001-2003, the WHO's World Mental Health Surveys Consortium assessed the lifetime prevalence of psychiatric disorder across 14 countries in different world regions. Lifetime prevalence estimates of any psychiatric disorder were found to range from 12% (Nigeria) to 47.4% (United States). The ratio of projected lifetime risk to lifetime prevalence was highest in countries exposed to sectarian violence (Israel, Nigeria, and South Africa) (Kessler et al., 2007). Assessment of 12 month prevalence rates demonstrated a high prevalence of mild and sub-threshold cases (ranging from 33.1% in Colombia to 80.9% in Nigeria), as compared to severe cases (WHO World Mental Health Survey Consortium, 2004). These numbers must be interpreted with an understanding of the methodological and conceptual limitations of assessing psychiatric disorder in various cultural contexts.

Mental Health in Conflict-Affected and Displaced Populations

Studies examining the prevalence of psychiatric disorder in displaced populations have yielded wide-ranging results in measures of depression, anxiety, and post-traumatic stress disorder (PTSD). For example, von Lersner, Wiens, Elbert, and Neuner (2008) found that among refugee returnees from Germany to country of origin, PTSD was detected for 31.0% of individuals, and depression for 31.9%. This compared to rates of 54.7% and 51.9% for refugees who remained in Germany. Among Albanian Kosovars in Switzerland, a rate of 23.5% for PTSD was found (Eytan, Gex-Fabry, Toscani, Deroo, Loutan, & Bovier, 2004). And among Guatemalan refugees in Mexico, 11.8% had symptoms of PTSD, 38.8% had symptoms of depression, and 54.4% had symptoms of anxiety (Sabin, Lopes Cardozo, Nackerud, Kaiser, & Varese, 2003). Situations of

displacement vary widely across context and have been measured using different instruments with varying levels of local adaptation. It is therefore difficult to draw any conclusive statements about the association between displacement and mental illness. However, as noted in a 2002 WHO publication, the majority of psychological reactions to conflict and highly stressful events are normative and often represent adaptive coping mechanisms. The intensity of stress and anxiety response symptoms naturally decline over time. When symptoms persist and disrupt daily functioning for a sustained period of time, they may transition from being adaptive to being dysfunctional (WHO, 2002).

Most of the research on the effectiveness of evidence-based mental health interventions has been conducted in high-income countries (Patel, Araya, Chatterjee, Chisholm, Cohen, De Silva et al., 2007). However, differences in health systems, socioeconomic conditions, and cultural systems in low and middle income countries are likely to significantly impact intervention effectiveness. Furthermore, individuals suffering from mental illness are often marginalized due to mental health stigma and have little recourse to appropriate care (Saraceno et al., 2007). In conflict-affected countries, the development of mental health services has often taken the form of non-governmental organization (NGO) programming. However, such programs are limited in scope, often have few resources and trained mental health personnel, and tend to be short-lived due to donor fatigue and a lack of political will. NGO mental health and psychosocial programs vary in quality and are not often evaluated for efficacy (Pupavac, 2002). Programs also vary widely in format and content.

There has been a rapid increase in the attention afforded to the psychological well-being of conflict-affected populations since the 1980s (Ingleby, 2005), as well as

an increase in the incorporation of psychological models into humanitarian assistance (Pupavac, 2006). Psychosocial assistance has been primarily driven by professional research interests and psychiatric definitions of mental health. The emergence and evolution of psychosocial programming has also been supported by humanitarian frameworks and donor interests. However, a narrow understanding of mental health on the part of policy-makers and donors often restricts the types of psychological programs that are funded and the breadth of work that practitioners are able to perform (Loughry, 2007).

A psychosocial model, also called an integrative or ecological model, is gradually replacing traditional psychotherapeutic approaches as the mode of choice for programs in conflict-affected contexts (Ager et al., 2006; Inter-Agency Standing Committee, 2007; Laor, Wolmer, Friedman, Spirman, & Knobler, 2005; Loughry, 2007; Miller & Rasco, 2004; Psychosocial Working Group, 2003; Salih & Galappatti, 2006; Silove, 2005; Sphere, 2004; Strang & Ager, 2005; van Ommeren et al., 2006; Williamson & Robinson, 2006). Psychosocial approaches in conflict settings tend to emphasize community capacity-building, informal household and social supports, the restructuring of social networks, and community participation. The 2007 publication of the Inter-Agency Standing Committee's (IASC) Guidelines on Mental Health and Psychosocial Support (MHPSS) in Emergency Settings stress inter-sectoral coordination, community participation and awareness of local context, social structures, and traditions. There are various types of psychosocial models that are applied in different public health contexts, although all models are essentially similar in their recognition of the social and psychological determinants of health. Psychosocial approaches define well-being as

including human capacity or capital, social connections and support, and culture or values, all of which exist dynamically within a broader framework of economic, physical and environmental structures.

Mental Health Care-Seeking and Management

The process of developing a public mental health system and community-based mental health services should include assessments of access to existing mental health and psychosocial services and exploration into care-seeking and management behaviors. The latter is imperative for understanding attitudes towards treatment and service use, existing care and management practices, and pathways to informal and formal services. As Pescosolido and Boyer (2010) define it: “How are these problems seen and interpreted by people? What kinds of help exist? How and when do people use the different sources of care that might be available to them?” (p. 421). Understanding these processes is important for determining what happens to people struggling with psychological problems, particularly as the majority of people with problems do not receive formal mental health treatment or experience years-long delays in receiving care (Pescosolido & Boyer). Developing effective and appropriate interventions will be facilitated by a consideration of existing management practices (Chapple & Rogers, 1999).

Care-seeking can be understood as the set of decisions, behaviors, and processes involved in seeking health care, as well as the factors that shape those processes. Care-seeking is traditionally measured as pathways to care. However, Pescosolido and colleagues have advocated for conceptualizing care-seeking as the combination of

“patterns and pathways of practices and people consulted during an episode of illness,” (p. 436) where “patterns of care encompass the combination of advisors and practices used during the course of an illness... [and] pathways add the element of order” (p. 436) (Pescosolido & Boyer, 2010; see also Pescosolido, 1991; Pescosolido, Gardner, & Lubell, 1998). This view is presented in Pescosolido’s Network Episode Model Phase II (NEM-II). This research employs this view of care-seeking and also utilizes the concept of management to further embed the notion that mental illness treatment and recovery is ongoing and dynamic (Anthony, 1993).

Rogler and Cortes (1993) define help-seeking pathways as the sequence of social contacts with individuals and institutions that are sought by a person in need of help. Many models of help-seeking pathways end in service utilization or access (Rogler & Cortes). Care-seeking should be understood more complexly (Corrigan, 2004); however little work has been done to conceptually delineate care-seeking behavior in mental health services research (Rogler & Cortes). There is a need to move beyond studies that consider care-seeking as a linear process that starts at symptom recognition and ends at utilization of services. Qualitative, in-depth exploration of care-seeking behavior is needed to fully articulate its multiple dimensions. This is particularly true given cultural variation in definitions and treatments of psychological problems. Mental health treatments and services may be provided by: 1) specialized mental health care professionals such as psychiatrists, psychologists, psychiatric nurses, and social workers; 2) primary care physicians or other providers of routine or emergency medical care; 3) alternative or folk healers and religious advisors; 4) informal care such as family, friends, support and self-help groups (Pescosolido & Boyer, 2010).

Illness management, particularly in the context of chronic illness, refers to the continuous treatment of illness, often times on one's own or within one's home and social setting and away from medical settings (Bury, Newbould & Taylor, 2005). Mental illness management has been defined as the broad set of strategies that help individuals with mental illness work with professionals, reduce susceptibility to illness, and effectively cope with symptoms (Mueser, Corrigan, Hilton, Tanzman, Schaub, Gingerich et al., 2002). Mueser et al. distinguish between professional illness management and lay or self-management. In this research management is defined as including self-management, as well as lay and professional strategies for management. Although management often refers to strategies employed after formal treatment is sought, in this research it also refers to care before formal services are accessed.

The concept of illness management is particularly apt for understanding mental health care strategies, as mental illnesses are very often chronic and dealt with by individuals and their social support systems (Bury et al., 2005). Management might be understood as regular care-seeking strategies that individuals utilize. Indeed, Pescosolido's NEM model presents care-seeking as a "social process managed through the social networks" that are all part of a larger, more complex social response to illness (Pescosolido & Boyer, 2010, p. 435). This social response to illness is shaped by historical forces and social context and is continually re-negotiated by individuals and their social networks. Parsons (1978 as cited in Bury et al.) put forth the notion of the "impairment role" as the chronic illness counterpart of his earlier "sick role." In the "impairment role," individuals attempt to meet daily activities but do so with a level of dysfunction. Since individuals suffering from chronic illness manage most of their

symptoms on their own, they often become better acquainted with their illnesses than do their doctors or psychologists. This idea affords particular value for the present research, as it helps explain the importance of investigating psychological problems experientially rather than diagnostically.

Perceived distress and need is subjectively experienced and shaped by individuals and their contexts (Pescosolido & Boyer, 2010). Self-management of mental illness often happens subconsciously. In the process of becoming aware of illness and moving towards a self-conscious decision to seek care, social contacts are involved in the response to illness. Research is needed to investigate how problems and symptoms are conceptualized and recognized and what social interactional processes factor into care-seeking and management. There is also a need for information on the types of informal strategies individuals utilize, and the informal services they access, to redress psychological problems. In Georgia, traditional therapies (e.g. herbal treatments, spell casting, religious practices) have not been integrated into the mental health care system. Medical professionals have indicated that traditional healing practices often lead to delays in formal service utilization. However, there is little available information on which traditional therapies in Georgia are preferred for different mental health problems (Sharashidze, Naneishvili, Silagadze, Begiashvili, Sulaberidze & Beria, 2004).

Social Support Structures

Mental illness is often addressed as an individual problem; however, it necessarily involves family members, friends, and social communities. The role of the household in the production of health and care-seeking (Berman, Kendall, & Bhattacharyya, 1994) is

particularly under-studied in mental health (Weine, Feetham, Kulauzovic, Besic, Lezic, Mujagic et al., 2008). Understanding care-seeking behavior within a household context is highly relevant within migrant or displaced communities, where social support systems are dense and heavily relied upon (Weine et al., 2008). In Georgia, the family plays a crucial role in treatment and care-seeking decision-making. Close family ties are considered important for avoiding loneliness, distress, negative feelings, and mental illness (Sharashidze et al., 2004). Understanding when and why individuals seek informal support within their social networks will aid in the development of culturally appropriate interventions that build on existing community support structures.

Theories of social relationships have differentiated between the structural aspects of relationships, for example the size and composition of networks, and the functional aspects of relationships, for example levels of perceived support or trust (Granovetter, 1985) and social cohesion or integration (Durkheim, 1897). This dissertation accounts for both subjective experience of displacement and the mediating effects of community, social environment, and social networks. Displacement and social integration processes reciprocally influence each other and shape the development of social support systems and participation in the community. Cutchin (2001) presents the process of place attachment and place integration as dynamic and incomplete.

Social ties and social support have been found to have protective effects across a range of physical and mental health outcomes (Berkman, Glass, Brissette & Seeman, 2000). However, Patel and Prince (2001) have cautioned against an assumption that social networks provide social support and care, particularly for older adults living in developing countries, where it is assumed that extended families provide care. They

found that participants expressed “dependency anxiety” or anxiety about becoming a burden on relatives (Vatuk, 1990 as cited in Patel & Prince), as well as anxiety about receiving inadequate support from family. Patel and Prince suggested that informal care-givers be supported through home-based programs using community health workers. In addition, alternative family care structures should be acknowledged and strengthened; an example of this is social care networks that take the form of intergenerational exchanges (Lewis, 2009).

Study Setting

The Internal Displacement Monitoring Centre has estimated that as many as 260,000 (Ministry of Internally Displaced Persons from the Occupied Territories, Accommodation and Refugees of Georgia, 2013) to 280,000 (Internal Displacement Monitoring Centre, 2013a) people are internally displaced in Georgia out of a total population of approximately 4.5 million. There are two cohorts of internally displaced persons (IDPs) in Georgia as a result of conflicts in the 1990s and in 2008, which resulted in individuals being displaced from the disputed territories of Abkhazia and South Ossetia (Internal Displacement Monitoring Centre). After Georgia declared independence from the newly dissolved Soviet Union in 1991, secessionist movements in the regions of Abkhazia and South Ossetia led to conflict from 1992 to 1993. The long-term IDP population, or ‘old’ cohort, was displaced during this conflict. Renewed conflict took place in South Ossetia in 2008, leading to a ‘new’ cohort of IDPs.

The majority of the long-term displaced population settled in Zugdidi, a city in the northwestern region of Samegrelo that borders Abkhazia, and Tbilisi, the capital city

in the central-eastern part of the country. Around 60% of the total IDP population is currently living in private accommodation, which for most has meant that they have self-settled into privately owned housing over the years. The rest, 40% or around 100,000 IDPs, live in government run shelters known as collective centers or compact settlements (Ministry of Internally Displaced Persons from the Occupied Territories, Accommodation and Refugees of Georgia, 2013). These centers were converted from a range of structures, including kindergartens, hotels, factories, and hospitals, into what was intended to be temporary shelter space for IDPs. The GoG supports IDPs' right to return and views return as necessary for regaining control over Abkhazia and South Ossetia (Ferris, Mooney, & Stark, 2011). However, since 2007, with the approval of its State Strategy for Internally Displaced Persons, the GoG has prioritized the local integration of displaced persons into host communities. Currently, this has involved implementing a series of durable housing policies, including handing over ownership of collective centers to IDPs through a process of privatization; limited renovations of collective centers; and the re-location of IDPs to other residences, including new apartment buildings, with private ownership (Dolidze, Tatishvili, & Chkhetia, 2005).

There are limited available data on prevalence estimates of psychiatric disorders within the general or IDP population in Georgia. A draft Georgian Mental Health Policy was assembled in 2009 by the Dutch organization, Global Initiative on Psychiatry. Citing official government statistics, the policy document reports that in 2007, 72,588 patients in state-run psychiatric institutions were registered, and 2,677 new cases were diagnosed. Serious and persistent mental illnesses were most prevalent, with schizophrenia, schizoid and delusional disorders representing 30.5% of cases and

mental retardation representing 28.5% of cases. The disorders that constituted the remaining percentage of cases were not reported. However, the report notes that Ministry statistics are limited for several reasons, including: an absence of population prevalence estimates; an underdeveloped patient registration system; low rates of access to state mental health services; and misdiagnosis due to lack of training or deliberate misdiagnosis for insurance coverage purposes (Global Initiative on Psychiatry, 2009).

The Georgian mental health system is currently characterized by a lack of trained mental health professionals, an emphasis on institutionalization for cases of serious mental illness, shortages in access to current classes of psychotropic drugs, and limited financial access (Global Initiative on Psychiatry, 2009). There is not currently a coordinated state community care system in place for a range of mental health conditions. Milner, Chanturidze, and Levett (2009) present the development of a community care system as an important objective for health systems development in Georgia. The majority of community based mental health and psychosocial programming has been provided by local non-governmental and international organizations (United Nations Office for the Coordination of Humanitarian Affairs, 2003 as cited in Sumbadze & Tarkhan-Mouravi, 2003). Such programming has served as a proxy community mental health system, and it is important to draw upon organizational experience in the development of the state mental health system in Georgia (Global Initiative on Psychiatry). However, particularly because such programs rely on international donors, such programs are limited in scope, are often available on a short-term basis, and are not part of a coherent service delivery program. There is no state-run program to support the mental health and psychological well-being of IDPs

(Internal Displacement Monitoring Centre, 2012a). The Georgian Ministry of Labour, Health, and Social Affairs' National Health Care Strategy for 2011-15 includes mental health system developments. In particular, the Strategy outlines increasing geographic access to psychiatric services, emphasizing continuity of care, upgrading facilities, building human resources, and increasing public awareness about mental illness.

The majority of available data on mental health among conflict-affected populations in Georgia, including IDPs, can be found in NGO program reports and needs assessments. Sumbadze and Tarkhan-Mouravi (2003) re-analyzed data from a 2002 Save the Children survey and found that the prevalence of depression is higher among IDPs in collective centers compared to the general public (12.9% compared to 11.8%). Zoidze and Djibuti (2004) have also found that Georgian IDPs described experiences of social stigma, which may be associated with levels of psychological distress. Stigma is often understood to be a mediating variable in the social and psychological experiences of illness and disease, with implications for treatment-seeking and management of disease (Cooper et al., 2003).

An October 2008 rapid needs assessment of women displaced after the August 2008 war in Georgia was carried out by the Georgian NGO, Institute for Policy Studies (IPS), with support from UNIFEM. The IPS assessment's qualitative findings demonstrated that IDPs experienced feelings of neglect, untimely assistance with leaving South Ossetia, and a lack of adequate information about assistance and prospects for return or resettlement. Further, IDPs had not been included in decision-making processes about their present and future circumstances. The assessment also found that displaced persons experienced anxiety about their security, and the security

of family members. IDPs were also found to have experienced psychological problems such as hyper arousal, insomnia, traumatic dreams, avoidance, intrusive thoughts, flashbacks, depression, and hopelessness, as well as somatic reactions such as hypertension, headaches, irritation, and digestive problems. Other problems included headaches, bed wetting, and sensitivity to noise among children, as well as problems with lactation among lactating mothers due to stress.

Many of these psychological and somatic problems can be attributed to the acute traumatic stress experienced in the immediate aftermath of disaster (WHO, 2002). However, the IPS assessment's findings are also suggestive of the more long-term consequences of displacement. The report found that many IDPs considered the experience of being an IDP to be humiliating and insulting. This humiliation was linked with being homeless and dependent on others for assistance. Further, the experience of being an IDP was linked with experiencing passivity, victimization, and constant waiting for support. The report contends that these experiences "threaten both female and male IDPs to a great extent and they want to do something about it, [sic] they would like to be active agents, subjects rather than objects in the processes that concern their lives and future. Both IDP women and men would like to be more involved in decision-making regarding the issues that concern their status and conditions" (Institute for Policy Studies, 2008, p. 17). The report also discussed relational problems experienced by IDPs, such as increased tension and conflict within the family, feelings of guilt among men likely due to an inability to protect their families and communities from conflict, domestic violence, and perceived increase of alcohol intake among men by women. In terms of access to mental health services, the assessment's survey of 1144 IDPs in

Tbilisi, Gori, and Kutaisi found that 35.3% of women and 24.5% of men had consulted a psychologist; the lowest proportion of children who have received a consultation from a psychologist was in Tbilisi, at 15.4%, while the highest was 64.1% in Kutaisi.

The Georgian Mental Health Coalition prepared a report on the mental health and psychosocial needs of conflict-affected communities in 2009. The report presented key findings from three needs assessments carried out by local NGOs and IOs with conflict-affected communities, including long-term IDPs, in the fall of 2008. Sample sizes were small for the surveys (n=290 and n=60), and information on sample design was not presented, so it is unclear how robust these findings are. However, findings suggested the following: high levels of anxiety, post-traumatic symptoms, sleeping problems, hopelessness, mood disturbances, feelings of being disgraced, as well as aggression and increased alcohol use by men and stress among children (Georgian Mental Health Coalition, 2009).

A brief presented by the Internal Displacement Monitoring Centre (IDMC) on the mental health of Georgian IDPs cited a 2011 IDMC and Brookings Institution study on differences in psychological well-being between male and female long-term IDPs. IDP participants in the study described men as having experienced greater levels of anxiety due to unemployment, inability to care for their families, changing social roles, and inability to cope with poverty compared to the standard of life they had experienced in Abkhazia. In response to unemployment and poverty, men were described as engaging in escapism, routine activities, and alcoholism. Conversely, women were described as having more easily adapted to changes, which often included becoming the primary breadwinners for their households (Internal Displacement Monitoring Centre, 2012a).

In 2009, the author conducted a pilot study on the health problems of long-term older adult Georgian IDPs. In-depth, semi-structured interviews were carried out with twenty one IDPs living in a collective center in Tbilisi. Results demonstrated that older IDPs experienced chronic health problems such as hypertension and diabetes, financial and physical barriers to health care access, social isolation, anxiety about their living circumstances, and a sense of alienation from the local community (Singh & Robinson, 2010). Findings from this study contributed to this dissertation.

Theoretical Framework

The theoretical framework for this dissertation incorporates several conceptual models. The first is Pescosolido's Network-Episode Model Phase II (NEM-II) (Pescosolido, 2006), which emphasizes the role of social support and networks in mental health care-seeking. The NEM-II is composed of four domains: social context or episode base, social support system, treatment system and an individual's "illness career" (Pescosolido). Existing theoretical approaches to health services utilization tend to assume that individuals make concrete, rational, and self-conscious choices, that service utilization can be equated with care-seeking, and that the role of culture and social networks is not primary (Pescosolido & Boyer, 2010). The NEM-II conceptualizes care-seeking (and, implicitly, management) as a dynamic and cyclical process. It allows for the examination of the factors and behaviors that precipitate utilization and affect continued use. Further, it views social context and networks as playing an active role in shaping problem recognition and decisions about care. The NEM-II also conceptualizes the treatment system as a key influencer of behavior and management patterns. The illness

career encapsulates “all of an individual’s attempts to cope with the onset of an episode of mental health problems, charting what is done and when it is done” (Pescosolido & Boyer, p. 436).

The theoretical framework also integrates concepts of mental health recovery. In particular, it draws on a conceptualization of recovery in mental illness as an ongoing, dynamic, and evolving process that involves both internal change and productive social interaction (Davidson & Roe, 2007; Jacobsen & Greenley, 2001; Substance Abuse and Mental Health Services Administration, 2011; Tondora, Heerema, Delphin, Andres-Hyman, O’Connell & Davidson, 2008). The United States Substance Abuse and Mental Health Services Administration’s (SAMHSA) model of recovery conceptualizes mental illness recovery as: “A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential” (Substance Abuse and Mental Health Services Administration, 2011). SAMHSA’s model includes four dimensions: 1) Health, or overcoming and managing disease; 2) Home, or having a stable and safe place to live; 3) Purpose, or having meaningful activities and social roles; and 4) Community, or relationships and social networks that provide support and hope. Achieving recovery means accessing and developing each of these domains.

A third key model within the theoretical framework is Ager and Strang’s (2004) model of integration within the context of displacement. This model includes the following core domains: Markers and Means (employment, housing, education, and health); Social Connection (social bridges, social bonds, and social links); Facilitators (language and cultural knowledge; safety and stability); and Foundation (rights and citizenship). Achieving integration according to this model means access to

employment, housing, education, and health care; social connectedness within and across groups in a community; consideration of displaced groups' particular linguistic and cultural needs; and the promotion of civic participation and legal protections.

Other models that have informed this dissertation are the WHO's model of effective coverage of health services (2001), as well as their Optimal Mix of Services for mental health care model (2003), the Inter-Agency Standing Committee's Guidelines on Mental Health and Psychosocial Support in Emergency Settings (IASC, 2007), and international normative guidelines on durable solutions to situations of displacement. This research has also been guided by an ethos of participatory work and involving mental health service users in the development of services (World Health Organization, 2008, p. 31). In addition, a human rights perspective that views the provision of appropriate and effective social and mental health services as a right of IDPs is a primary impetus of this work.

Overview of Chapters

This dissertation presents three separate but linked studies. Chapter 2 (Methodological Orientation, Study Methods, and Data Analysis) presents an overview of the epistemological and methodological orientations used in this research. The chapter also details the data collection and analysis methods used in each of the three studies.

Chapter 3 (Idioms of Distress and Everyday Problems among Older Adult Internally Displaced Persons in Georgia: A Qualitative Inquiry) presents the results of Study 1 in a paper format. Chapter 4 ('Getting Used to It': A Grounded Theory of Living with Displacement and Becoming Integrated among the Long-term Internally Displaced in

Georgia) presents the results of Study 2 in an extended paper or monograph format. Chapter 5 (Narratives of Mental Health Care-Seeking among the Long-term Internally Displaced in Georgia) presents the results of Study 3. Since data collection and analysis procedures for Studies 2 and 3 were closely linked, both studies draw on similar literature and theoretical concepts. Chapter 5, therefore, is formatted to immediately present study results and conclusions. Finally, Chapter 6 (Discussion of Findings, Implications, and Next Steps) presents overall conclusions, emerging theoretical and research directions, and program and policy recommendations. References and Appendices are presented at the end of the dissertation.

Chapter 2. Methodological Orientation, Study Methods, and Data Analysis

Outline of Methods Chapter

This chapter will first provide an overview of the epistemological orientation and use of qualitative methods in this dissertation. Next, a separate section will review the methodology, data collection, and analysis procedures used in Study 1 (Chapter 3). This chapter will then present the methodology used in Studies 2 and 3 (Chapters 4 and 5), including a review of Grounded Theory methods.

Reflexivity and Ways of Knowing: Ontological, Ethical, and Epistemological Orientations

I began research for this dissertation with an understanding that my stance as a researcher is dependent on three tenets I hold to be true. The first is that processes of knowing are dynamic, negotiated, co-constructed, and relational. The second is that despite the ever-changing nature of ontological meaning, experiences and conditions can be understood at a sufficient enough level to be acted upon. The third is that my ethical obligation as a researcher, particularly in the health sciences, is to address research questions and present findings in ways that ultimately benefit participants and their communities. That is, it is my responsibility to communicate disparate ways of knowing and feeling in ways that are useful to scientists, practitioners, and policy-makers, and in ways that credibly reflect participants' experiences.

Ensuring that participants' experiences are expressed through study findings and conclusions is itself a negotiated process. Data analysis requires an analytical move to the conceptual and away from the micro-level delineations and details of individuals' lives. This is true across the continuum of qualitative and quantitative methods. Yet, the process of data 'cleaning' and the extraction of meaning from data units must not sterilize or strip the data of the particularities of participants' social worlds. Removing data from the historical and social contexts in which they are necessarily situated risks compromising not only interpretations of the data, but participants' voices as well. The research encounter should open up a space for participants to articulate their experiences. In her book, *Decolonizing Methodologies: Research and Indigenous Peoples (2nd Edition)* (2013), Linda Tuhiwai Smith examines the act of writing about, by, and for historically disenfranchised communities. She points to Edward Said who asks, who is writing, for whom, and in what circumstances? (Said, 1983 as cited in Smith). The collection and writing of others' experiences often reflects structures of hegemony. However, Smith identifies imaginative and linguistic space (and by extension, acts of conceptualization, analysis, and writing) as having potential for spreading influence to historically disempowered groups; she refers to Toni Morrison's affirmation that imagination is a means for sharing the world (Morrison, 1993 as cited in Smith). Rosi Braidotti, a critical theorist who has written on nomadic theory—a conceptual approach utilized in Chapter 4—articulates this further: "Creativity is a nomadic process in that it entails the active displacement of dominant formations of identity, memory, and identification" (Braidotti, 2011, p. 235).

Collective imaginings of historical and lived experience is not an uncontested

process. Smith (2013) refers to what Morrison (1993 as cited in Smith) has identified as the struggle of writing and living within shared interpretive spaces. Smith's interest is in understanding how members of indigenous or other marginalized communities "write back" (p. 38) to hegemonic structures of knowledge production. In this dissertation, I am not one of those who is "writing back." However, I view it as my ethical responsibility to open up and provide an imaginative space of experiences of displacement, mental illness, and community belonging on behalf of my participants. It is, therefore, the researcher's responsibility to create, through writing and dissemination, a space in which under-represented voices can respond. The reader should also not be deprived of the opportunity to link the conceptual to the personal and to locate herself while participating in her own analysis of study findings. Indeed, analysis does not stop at publication, as readers continue to contribute their own interpretations of findings to shared imaginative spaces.

The researcher is also a participant in the research process (Creswell, 2007). Data analysis and writing involves the "practice of accountability for one's embodied and embedded locations, as a relational, collective activity of undoing power differentials. . ." (Braidotti, 2011, p. 216). That is, critical analysis involves accounting for my own identity, sense of place, and geographic location. This includes accounting for the effects of interpretation on my experiences working in global health, traveling to and living in different countries while having membership in U.S. society, being Western educated (with implications for the imposition of epistemologies and methodologies), and possessing an identity that is dispersed across communities as a first generation Indian-American. My own experiences with multiple locales of identity, belonging, and

community have shaped my understandings of these themes within this dissertation. In addition, my interests in experiences of displacement and local integration are shaped by my prior training in forced migration and refugee studies, as well as my family's experiences during the Partition of India in 1947. This was an event that produced the largest migration of refugees thus far in recorded history. My family's shared history has also been shaped by an earlier forced migration: that of the Persian Zoroastrians to India in the 7th to 10th centuries C.E. The geographical region that Georgia now covers was once part of the Persian Empire; in Tbilisi, there still stands the ruins of an ancient Zoroastrian temple. Whether through this shared history or through observed commonalities in experiences of 'in-betweenness,' my connection to my dissertation study site is multi-stranded. As Smith (2013) writes: "There are also researchers, scholars and academics who actively choose the margins, who choose to study people marginalized by society, who themselves have come from the margins or who see their intellectual purpose as being scholars who will work for, with, and alongside communities who occupy the margins of society" (p. 207).

The research encounter is a dialogical space shaped by multiple actors, including study participants who actively negotiate this space and their own conveyance of experience and production of meaning. This is facilitated by the researcher's personal sense of compassion towards participants' experiences: "Empathy and compassion are key features of this nomadic yearning for in-depth transformation. Proximity, attraction, or intellectual sympathy is both a topological and qualitative notion: it is a question of ethical temperature. It calls for an affective framing for the becoming of subjects as sensible or intelligent matter" (Braidotti, 2011, p. 229-230). The researcher

thus has the ability to position what is personal, psychological and experiential within wider institutional and intellectual environments.

A compassionate and ethical standpoint must also consider the relative ethics of narrative research. The potential harms to human subjects and the relative risks and benefits of the methods used in this dissertation were reviewed by ethics boards; however, what are the implications of research on the collective social experience? Smith (2013) writes about: “the remembering of a painful past, re-membering in terms of connecting bodies with place and experience, and, importantly people’s response to that pain” (p. 147). Whose pain is narrated and for whose benefit? And how does the telling impact the teller, not just in terms of re-experienced pain but in terms of the relinquishing or claiming of one’s own story? Who owns the story and who gets to tell it in the end? Whose voices are privileged among those who are under-privileged? Recollections and narrations of past and present experiences, particularly among marginalized groups, impact not just individuals but entire representations of groups. Yet, this process of sharing stories and telling is ultimately what qualitative and narrative research is about. Research participants in the analyses that comprise this dissertation all emphasized the power of sharing and talking in their own healing and recovery processes. Telling and re-telling, particularly to outsiders, reconstitutes experience as object rather than just subject. The telling of experience turns it into something that can be responded to and understood. Smith (2013), writing as a member of the Maori community, explains: “As a site of struggle research has a significance for indigenous peoples that is embedded in our history under the gaze of Western imperialism and Western science. It is framed by our attempts to escape the penetration

and surveillance of that gaze whilst simultaneously reordering and reconstituting ourselves as indigenous human beings in a state of ongoing crisis” (p. 41). Thus, recollection and narration allows for processes of representation to occur; it allows for acknowledgment of the struggles of marginalization as well as for the development of a collective voice.

In this research, I rely on an interpretive ontology and a constructivist epistemology. Charmaz (2006), who advocates for a constructivist approach to Grounded Theory methodology, writes that interpretive theory “calls for the imaginative understanding of the studied phenomenon. This type of theory assumes emergent, multiple realities; indeterminacy; facts and values as inextricably linked; truth as provisional; and social life as processual” (p. 127). Emphasis is therefore placed on understanding studied phenomena at conceptual levels and as shaped by the subjectivities of both the researcher and participants. An interpretive ontology assumes uncertainty and prioritizes patterns and connections rather than measured fact. A constructivist epistemology is concerned with the co-construction of meaning, as it “places priority on the phenomena of study and sees both data and analysis as created from shared experiences and relationships with participants and other sources of data” (Charmaz, p. 130). In addition, a constructivist view of research acknowledges that research findings and conclusions are interpretations shaped by the researcher: “The [resulting] theory *depends* on the researcher’s view; it does not and cannot stand outside of it” (Charmaz, p. 130). A constructivist view acknowledges the historical, political and social contexts in which research is situated. It does not assume an essential truth but acknowledges that, with careful research, an understanding of a given

context and process can be reached. I also draw on a pragmatic epistemology, which privileges practice and whether research findings, theories, and concepts ultimately support goals of practice: “In pragmatic philosophy, meanings emerge through practical actions to solve problems, and through actions people come to know the world” (Charmaz, p. 188). Pragmatism conforms to constructivist views as it also considers truth to be relative, interpreted, and fluid. As a public health researcher, a pragmatic epistemology is useful as it acknowledges that while meaning is interpreted and co-created, the ‘truth’ or value of interpretations is in the end determined by their usefulness in people’s lives; the credibility of findings and theoretical concepts is in their effects on practice and health outcomes.

Choosing Qualitative Methods

Qualitative inquiry, particularly the qualitative analysis process, requires a degree of comfort with what is unclear and uncertain, particularly within an interpretive framework. The researcher operates within a creative and imaginative space and, with rigorous methods in place, is simultaneously moving towards and shaping the research product. This space is what Braidotti (2011) terms the “creative void”: “The form, or the discursive event, rather emerges from the creative encounter of the doer and the deed or from the active process of becoming” (p. 234). A qualitative research design here conformed to a constructivist epistemology and allowed for the exploration of participants’ experiences with each other, their social networks, and their own imaginations and memories.

Qualitative data provides information on knowledge, feelings, processes,

behaviors, experiences, and context. Qualitative methods are useful for studying such phenomena as illness categories, stigma, disclosure, decision-making, treatment experiences, health worker experiences, and social systems. In addition, qualitative methods are useful for investigating social processes, behaviors, and trajectories such as social integration, care-seeking and recovery: “Qualitative inquiry enables rich descriptions of these changes over time, while at the same time attending to the mechanism of change” (Morse, 2012, p. 67). Morse has defined qualitative methods within health research as a distinct discipline of “qualitative health research”: *“Qualitative Health Research is a research approach to exploring health and illness as they are perceived by the people themselves, rather than from the researcher’s perspective. Researchers use qualitative research methods to elicit emotions and perspectives, beliefs and values, and actions and behaviors, and to understand the participants’ responses to health and illness and the meanings they construct about the experience”* (p. 21). Morse identifies two parameters of qualitative health research: a focus on the health-illness continuum and the use of inductive methods to gather information on individuals’ or groups’ perspectives and behaviors: “Qualitative health researchers are interested in people and their lives, and in their problems as people, focusing on their perceived or experienced health status, or using their diseases or health states as background or context” (p. 20).

Qualitative health research often relies on narrative interviewing methods. The narrative and the telling of self, like interpretation of meaning, is negotiated and co-constructed; it is dynamic, non-linear, fragmented and sometimes contradictory. Sermijn, Devlieger, and Loots (2008) use Deleuze and Guattari’s (1976 as cited in

Sermijn et al.) metaphor of the rhizome to explore the process of narrative construction of self. They explain a rhizome as “an underground root system, a dynamic, open, decentralized network that branches out to all sides unpredictably and horizontally. . .it has *multiple entryways*. . .There is no main entry way or starting point that leads to “the truth” . . . There are always many possible truths and realities that can all be viewed as social constructs” (p. 637). Similarly, narrating the self is a multi-voiced and incomplete process; there is no fixed or stable self that can be captured through the interview process. Time is nonlinearly organized and space is constantly in flux. Narratives of care-seeking behaviors, therefore, will likely not be presented in terms of discrete events, points in time, or as a coherent story. Sermijn et al. suggest that selfhood as rhizomatic has multiple entryways, with “each entryway [leading] to a temporary rendering of selfhood” (p. 638). Through the telling that occurs in the research encounter, participants create and relay multiple aspects of self, alongside the researcher, who also contributes to this construction: “The stories that participant and researcher co-construct thus offer no more than a fleeting glimpse of the multitude of possible stories that could be constructed. At the moment when the participant speaks about herself or himself, she or he creates a momentary, context-bounded self” (Sermijn et al., p. 641). In this dissertation, it is not assumed that the narratives and data collected from Georgian IDPs about social support, mental illness, and integration are a complete reflection of participants’ experiences: “one can never have a complete map of one’s participant, seeing that this map is co-constructed, multiple, and constantly changing” (Sermijn et al., p. 644). Nevertheless, this does not mean that the self that is created and conveyed is not real or meaningful in that moment, particularly as

participants also seek unity and coherence in their understandings of themselves. There is value and meaning in the narrative self that becomes known through the interview encounter.

Methodology for Study 1

The first study in this dissertation examines older adult Georgian IDPs' experiences of mental health problems and displacement. This study was the initial, qualitative research phase of an investigation assessing the health status of older adult Georgian IDPs. This investigation was titled: 'Aging in Displacement: Assessing Health Status of Displaced Older Adults in the Republic of Georgia.' The investigation was run by the Johns Hopkins Center for Refugee and Disaster Response (P.I. Courtland Robinson) with a local partner, the Institute for Policy Studies. The study utilized the linked methods of free list and key informant interviews. This methodology was adapted from an approach that has been employed and validated in numerous studies on global mental health topics, including among street-children in Georgia (Murray et al., 2012). Cutchin (2001) and Rowles (1983) advocate for qualitative methods as a means for accessing the relationship between migration and aging. Qualitative methods, including semi-structured interviews and free-lists, are also effective methods for eliciting illness narratives, local idioms of distress, as well as ethnomedical terms and knowledge (Kohrt & Hruschka, 2010). The often ill-defined parameters of mental illness constructs across settings and the extent to which these constructs are influenced by context requires that they be measured using indicators and terms that are consistent with the study setting. This, in part, means moving beyond the simple translation of measures to adapting

wording and adding indicators in order to integrate local interpretations and experiences of mental health, illness, and functioning. An approach that is open-ended, flexible, and emphasizes narrative expressions of experiences is particularly useful for navigating potential differences and discrepancies between standard psychiatric and ethno-psychiatric definitions of mental health and illness.

This approach of combining free list and key informant interviews is broadly characterized as ‘qualitative.’ However, free listing is more accurately described as a form of systematic data collection (Weller & Romney, 1988). Free listing has its origins in cognitive anthropology, and its primary purpose is to textually map individual cognitive domains. That is, free list interviews aim to identify all items, or ‘included terms,’ that belong to a given category or cognitive domain. This is accomplished by asking respondents a primary question, which typically is to list all instances of the category of interest that respondents can call to mind. Secondary questions may be included to collect further details about this category. Free list data can be analyzed both qualitatively, through the identification of key themes, the relationships between them, and the words used to describe them, as well as quantitatively, through frequency calculations of listed items. Frequency calculations provide information on the extent to which respondents believe that certain items ‘belong’ to or make up the given category. It is useful to examine how often items are mentioned because this can indicate the extent to which certain topics or problems are readily accessible and thought about in a community. However, items may be infrequently mentioned because they relate to a sensitive topic or to topics that are difficult to list as distinct items and may retain significance and warrant further investigation.

In-depth interviews are often utilized in conjunction with free list interviews, as they provide more textually rich data and are useful for contextualizing, elaborating upon, and interpreting free list data. Interviews may also be useful for identifying local categories to enquire about during free listing. Understanding the mental health status and needs of older adult IDPs was a key objective of the larger investigation. Key informant interviews were used to gather in-depth information on themes from the free lists that specifically referred to mental health or psychological problems. These themes did not tend to be frequently mentioned, perhaps given the sensitive nature of mental health topics. The key informant interviews provided the opportunity to learn more about mental health problems and how they were talked about from the perspectives of knowledgeable community members.

Planning and Timeline of Activities

This investigation comprised three phases: qualitative inquiry, instrument development and validation, and a prevalence study, as well as a small case study of Chechen refugees. Field work for all aspects of the investigation took place between September 2010 and August 2011. Fieldwork for the qualitative study took place between October 2010 and March 2011 and was carried out in three study regions across Georgia: Samegrelo, Shida Kartli, and Tbilisi.

Ethical Clearance

The study protocol, consent forms, and instruments were reviewed by U.S. and Georgian institutional review boards in accordance with standard research procedures. These IRBs are located at the Johns Hopkins Bloomberg School of Public Health in Baltimore, U.S. and the National Center for Disease Control and Public Health in Tbilisi, Georgia. The study was granted permission to proceed before data collection commenced. Data collection procedures were also reviewed with Georgian staff at the local collaborating research organization to ensure that the protocol and data collection instruments were locally appropriate.

Hiring, Training, and Supervision of Research Assistants

The local collaborating research organization for this study was the Georgian NGO, Institute for Policy Studies (IPS), based in Tbilisi. A team of six field interviewers and one field supervisor (all female and Georgian) employed at IPS were trained in the study protocol over the course of several days by the author. Although all interviewers were experienced in qualitative research methods and interviewing, the training also involved a review of qualitative interviewing techniques and particularly focused on the method of free listing. Interviewers had significant experience in research with displaced communities.

Study Sample

In total, 120 respondents were interviewed in the study, including both free list and key informant interview respondents. All respondents were sampled from rural/ peri-urban and urban sites in the three study regions of Samegrelo, Shida Kartli, and Tbilisi. Free list interviews were carried out solely with IDPs. The following inclusion criteria were used for free list respondents: 1) IDPs from either the new or the old case-load; 2) Residing in one of the three study regions; 3) Aged 60 and older. Respondents from Tbilisi and Zugdidi were all from the old case-load, whereas respondents from Shida Kartli were from both case-loads, but primarily the new. IDPs living in all settlement types were sampled, including private accommodation, collective centers and compact settlements (both state and privately owned), and new settlements. With the assistance of local service organizations that worked with IDP communities, respondents were purposively sampled in order to represent both sexes, different ages within the target age bracket, locations, and settlement type. In total, 75 free list respondents were interviewed, with 25 respondents per study region.

Key informant interviews were carried out with a range of community members who were identified as being knowledgeable about issues concerning older adult IDPs. Key informants were not restricted to any social or age group. Inclusion criteria were: adult community members who were 1) residing and/or working in one of the three study regions and 2) knowledgeable about issues of concern to older adult IDPs. Key informants were selected from all three study regions, from both urban and non-urban sites. Key informants were both IDPs and non-IDPs, and included community leaders, government representatives, lawyers, NGO workers, doctors, psychiatrists, and social

workers. Key informants were purposively selected based on recommendations made by free list respondents during interviews and by IPS senior research staff familiar with service organizations in the study sites. In total, 45 key informants were interviewed, with 15 informants per study region.

Data Collection Methods

Free list interviews were made up of five questions. Question 1 was intentionally framed as a broad, open-ended question to elicit a wide range of responses and to find out what community members themselves considered important problems. Questions 2-5 were follow-up questions that were intended to gather data on how respondents related to others, particularly their families, as well as on how well they were able to function and carry out daily activities. Finally, participants were asked to recommend community members who were knowledgeable about the problems facing older adult IDPs.

1. What are the major problems that displaced older adults (ages 60 years and older) have?
2. What are the major problems displaced older adults have that affect their families?
3. What routine tasks do displaced older adults do to take care of themselves?
4. What routine tasks do displaced older adults do to take care of their families?
5. What routine tasks do displaced older adults do to participate in the community?

Free list and key informant interviews were sequentially carried out in each study region. Data collection trips were jointly coordinated and supervised by the IPS field supervisor and the author. Free list questions were compiled onto a free list form. Free list interviews lasted approximately 45 minutes. The interviewer posed each question and asked the respondent to list his/her responses. When the respondent had completed listing responses for a given question, the interviewer moved on to the second question.

Interviews were conducted by pairs of field interviewers, with the first interviewer posing the questions and the second taking detailed hand-written notes of responses. None of the interviews were digitally recorded, and all were conducted in Georgian.

In order to identify important content areas to follow up on in the key informant interviews, data from free list forms were entered into Excel spreadsheets and coded for summary themes that represented each listing. Frequency calculations were run on these themes. Frequencies, themes, and detailed content were reviewed by the study team to identify themes and responses that specifically had to do with mental health or psychological problems and which seemed to hold significance within the study population. Selected themes for key informant interviews differed slightly across study sites, depending on what free list responses were given in each.

Key informant interviews in each study region were carried out three to four weeks after free list interviews were completed. The key informant interview involved inquiring about associated thoughts, feelings, and behaviors for each selected core theme. Examining this phenomenological triad is essential for diagnosing mental illness in clinical settings and, as such, is also useful in research settings for uncovering and describing mental health problems from multiple angles. Key informant interviews lasted approximately one hour. The interviewer posed each question and allowed the respondent to answer; the interviewer then asked additional probing questions to gather more in-depth information. Once again, interviews were conducted by pairs of field interviewers in Georgian and were not digitally recorded.

Data Analysis

Initial data analyses took place while data collection was ongoing. During data collection periods, interviewer pairs regularly reviewed their written notes with each other and the rest of the field team. Interviewers also shared their initial interpretations of responses during group reflection meetings that occurred after each site visit. Interview data were initially rapidly analyzed in the field by the local team and were then reviewed by the rest of the study team. Analysis involved the simultaneous entering and coding of textual interview data using standardized Excel forms. When applying thematic codes to interview text, an attempt was made to both summarize the text and to represent key phrases and terms that were used in that text. English translations were subsequently added into the forms. Since the free list interviews collected data as separate items, it was straightforward to enter them as separate text segments. Entering text from the key informant interviews involved systematically isolating segments of text that corresponded with categories of perceived cause, symptoms/signs, associated problems, and coping mechanisms. Frequency calculations were then run on the thematic codes that corresponded with segments of text. Subsequent analyses took place on-site at JHSPH by the author. This involved reading through all responses with a focus on the context surrounding specific themes and the connections respondents made between different themes.

Credibility

Trustworthiness of data collected was established through several procedures. First, feedback from IPS staff was regularly solicited and gathered before and during the data

collection process to ensure the study protocol was locally appropriate and to inform the development of interview questions. Reflections with field interviewers were regularly carried out after data collection trips to gather interviewers' feedback on the data collection process, insight into the study population and context, and initial interpretations of interview data. Survey data from the later phases of the investigation allowed for comparisons of key findings using different data collection methods. The study methodology and findings were presented in several forums in Georgia and the U.S., including to a Georgian audience comprised of policy-makers, local researchers, and selected study key informants.

Methodology for Studies 2 and 3

Grounded Theory was the methodology that primarily shaped the data collection and analysis processes for Studies 2 and 3. This methodology was first developed by Glaser and Strauss in 1967; further iterations have been elaborated by Strauss and Corbin (1990) and Charmaz (1990; 2006). Grounded Theory was chosen because it is particularly well suited for studies of trajectories, behaviors, transformations, and social processes (Morse, 2012). Grounded Theory allows for closer examinations of individuals' actions, as well as social interactions, over time (Holloway & Brown, 2012). These qualities made Grounded Theory appropriate for studying the transformative social processes examined within Chapters 4 and 5—in particular, social support seeking, care-seeking for mental health problems, and becoming socially integrated into communities. The impetus of Grounded Theory is to understand a social process or phenomenon from the perspectives of local actors and to produce theoretical categories

and constructs that are ‘grounded’ in participants’ own voices. Grounded Theory methods may lead to the development of new theory or to the refinement of existing theory. Regardless, the emphasis is on conceptual development of themes as opposed to description (Glaser, 2012). Through this process of theory development, a Grounded Theory methodology is oriented towards movement and change in its output. Grounded Theory is also oriented towards informing social programs and interventions and is therefore relevant for public health research.

One of the reasons why Grounded Theory is useful for studying social interactions, processes, and trajectories is because the methodology itself is inherently dynamic. Thus, Grounded Theory methods account for the fact that as new information is uncovered during data collection, the researcher’s investigative path will likely shift to accommodate this information and explore new theoretical terrain. Grounded Theory methods take an iterative approach to the design of research questions, interview questions, and sampling strategies. Data collection and analyses are also carried out in an interactive and iterative fashion. One of the hallmarks of Grounded Theory is theoretical sampling, which explicitly encourages the researcher to diverge from previously determined paths of inquiry to explore new topics, themes, and ideas, as they emerge. A key goal in Grounded Theory is the identification of a core category, which “develops the storyline [and] integrates all elements of the emergent theory” (Holloway & Brown, 2012, p. 44). This is accomplished through iterative data collection and analysis, theoretical sampling, as well as coding, categorizing, and memo-writing processes. Given this iterative design, how does one know when to stop collecting data? As Glaser (2012) has written: “Its [substantive grounded theory’s] discovery is an

unending conceptualization, and the researcher should not attempt the unending generating of the theory.” The goal of Grounded Theory, in Glaser’s conception, is to produce a workable theory that is generally applicable in a range of settings at the abstract, conceptual level.

Studies 2 and 3 employed Charmaz’s (1990, 2006) interpretation of Grounded Theory, which is based on a constructivist epistemology and understanding of the research encounter as being co-created: “A social constructionist Grounded Theory views the process of categorization as dialectical and active, rather than as given in the reality and passively observed by any trained observer” (Charmaz, 1990, p. 1165). Applying a constructivist perspective in line with Charmaz’s approach furthers the dynamic and energetic nature of Grounded Theory research. Charmaz’s constructivist Grounded Theory also integrates interpretive and phenomenological orientations to meaning. One of the critique’s of Charmaz’s interpretation of Grounded Theory is that in its constructivism, it can become too unstructured and open-ended. Differences in structure among the various versions of Grounded Theory are products of their differing epistemological orientations.

Planning and Timeline of Activities

Protocol development and planning took place in 2010, while data collection took place between 2010 and 2012. First, lists of IDP government shelters, or collective centers, were obtained from the then named Ministry of Refugees and Accommodation (now: Ministry of Internally Displaced Persons from the Occupied Territories, Accommodation and Refugees of Georgia). Initial site visits were carried out to Zugdidi

in the fall of 2010 which included identifying and visiting the locations of several collective centers. The planning phase also involved beginning the hiring process for research assistants and engaging in informal conversations with local experts. During the fall of 2010, key informant interviews were begun as well. Further key informant interviews and interviews with IDPs were carried out in 2011 (for Study 3), with an additional round of key informant and IDP interviews carried out in 2012 (for Study 2).

Ethical Clearance

The study protocol, recruitment scripts, consent forms, and instruments were reviewed by U.S. and Georgian institutional review boards in accordance with standard research procedures. These IRBs are located at the Johns Hopkins Bloomberg School of Public Health in Baltimore, U.S. and the National Center for Disease Control and Public Health in Tbilisi, Georgia. The study protocol and amendments to the protocol were approved before data collection commenced. The Georgian NGO that was the local collaborating partner for Study 1, the Institute for Policy Studies, was consulted with throughout data collection procedures; this was done to ensure that the protocol, data collection instruments, and compensation amounts were locally appropriate. Another organization in Zugdidi was identified as a mental health provider to whom IDP participants could be referred in case of distress that occurred as a result of participation. No participants were referred because of distress reactions.

Hiring, Training, and Supervision of Research Assistants

In the fall of 2010, hiring processes were begun by circulating a position announcement to an email list-serve of Georgians who had received scholarships from the international non-profit organization, IREX; these individuals had recently returned from completing graduate degrees in the U.S. or Europe funded by IREX. This candidate pool was selected because individuals were all native Georgians who spoke English at an advanced level, had received graduate degrees in the social sciences and understood the basics of the research process, and had experience working within Western educational guidelines and frameworks. Resumes were reviewed, and in-person interviews were carried out by the author with short-listed candidates in December 2010 and January 2011. Essential criteria for selection included fluency in both Georgian and Russian and experience in social science research.

The two core research assistants who were hired also had experience working with IDP populations, working in interview contexts, and good inter-personal and communication skills. One research assistant was also a member of the IDP community and spoke Mingrelian, a Kartvelian language related to Georgian and spoken in the western region of Samegrelo. Two additional research assistants were utilized for several interviews during data collection for logistical reasons; these interviewers had experience working with IDPs, qualitative methods, and on mental health research. All interviewers were native Georgians, female, and in their 20s and 30s. Research assistants were trained using a combination of didactic and interactive methods, such as role-playing, and were trained in the study protocol, ethical conduct of human subjects research, interviewing techniques, and mental health concepts. Training also involved

the review of initial IDP interview guide questions to gather feedback on wording. Research assistants initially accompanied the author on key informant interviews to observe the interview process. The author attended and observed IDP interviews throughout data collection and provided supervision and feedback. Transcripts were also reviewed in order to provide on-going feedback about interviewing.

Data Collection Methods

Site Observations: Visits were made to various collective centers and mental health service sites. During these visits, ethnographic observations were carried out. This included talking to IDP residents and service providers during interviews, taking note of conditions and facilities, recording observations as hand-written field notes, and taking photographs for record-keeping purposes. Mental health service sites included the offices of several NGOs in Tbilisi, Gori, Zugdidi, and Akhmeta (a city in eastern Georgia where Chechen refugees live) that provide mental health and psychosocial services, as well as other services, to conflict-affected and IDP populations. In addition, visits were made to a long-term inpatient psychiatric facility in Tbilisi, a crisis/ emergency care inpatient psychiatric facility in Tbilisi, an outpatient psychiatric unit in Zugdidi, an NGO in Zugdidi that helps individuals with substance use recovery, an NGO in Zugdidi that helps disabled individuals and older adults, an alternative medicine phitotherapy (herbal therapy) clinic in Tbilisi, and an outpatient medical facility in Tbilisi. As part of Study 1 procedures, visits were also made to the offices of UNHCR in Tbilisi, Gori, and Zugdidi, to UNHCR implementing partners in Gori and Zugdidi, and to U.S. State

Department offices in Tbilisi; information gathered from these visits also informed Studies 2 and 3. Finally, visits were made to international humanitarian organizations.

Ethnographic observations were also carried out during visits to a compact settlement in Tbilisi and collective centers in Zugdidi (visits to collective centers in Tbilisi and settlements for 2008 IDPs in Shida Kartli were carried out as part of procedures for Study 1). Collective centers were purposively selected to represent a range of building types, population sizes, and locations within the city. Selected centers included a former paper factory, kindergarten, hotel, and a building that earlier belonged to a hospital, among others. The locations and approximate sizes of collective center populations were ascertained by reviewing lists from the MRA; however, population sizes listed in MRA records did not always reflect actual sizes, as determined by participants' descriptions and our own observations. Thus, initial visits were made to prospective centers to assess living conditions and approximate population sizes before selecting centers for interview data collection.

Key Informant Interviews: In-depth, semi-structured interviews were carried out between 2010 and 2012 with 20 key informants; two of these key informants were followed up with and interviewed for a second time. The primary aim of these interviews was to collect information on mental health and psychosocial services within Georgia, observed care-seeking behaviors of patients, perceived mental health needs of the IDP and general population, and other needs of IDPs. Interviews were carried out with 17 women and 3 men, including:

- 6 Heads of NGOs and associations that address mental health and/or IDP issues; most of these are also trained psychiatrists or psychologists
- 3 Psychologists at NGOs that address mental health and IDP issues
- 1 Psychiatrist who works for a religious organization that provides psycho-social rehabilitation for addiction
- 1 Psychiatrist who works at both long-term and emergency inpatient psychiatric facilities
- 1 Psychiatrist who works at an outpatient psychiatric unit
- 1 Psychiatrist who has studied *batonebi* (local mental health construct) in-depth
- 3 Georgian researchers (an anthropologist, ethnologist, and social scientist)
- 1 Doctor at a herbal treatment center
- 1 Priest
- 1 Nun
- 1 Foreign head of a humanitarian organization

The author carried out most of the key informant interviews in English; some were carried out in English and Russian. Other interviews were carried out by research assistants in Georgian. The interview guide was semi-structured and iteratively developed to address emerging thematic content from ongoing IDP interviews, as well as to address the particular expertise and backgrounds of different key informants. Most interviews were digitally recorded; two key informants asked not to be recorded. Key informant interviews were selectively transcribed and analyzed.

Semi-structured Interviews with IDPs: In-depth, semi-structured interviews were carried out with 49 adult (ages 18 and over) long-term Georgian IDPs. The sample of 49 IDPs comprised 33 women and 16 men, ranging in age from 18 to 79. All interviews were digitally recorded; sessions lasted between 45 to 120 minutes, with most lasting approximately 60 minutes.

Out of this sample, 39 IDPs were interviewed over the course of two sessions in 2011; this included a sub-sample of 9 IDPs who had accessed formal services and were identified through two providers. The two interview sessions were typically carried out within a few days of one another. Participants were compensated 20 lari (approximately US\$11) for their participation in both sessions. Most of these 39 participants lived in urban collective centers in Zugdidi. Since the sub-sample of 9 IDPs was identified through two providers (a state-run outpatient psychiatric dispensary in Zugdidi and an NGO providing psychosocial services to IDPs in Zugdidi), some lived in private accommodation and in villages around Zugdidi; two individuals in the sub-sample lived in a new apartment complex for relocated IDPs in the port city of Poti, about an hour south of Zugdidi along the coast of the Black Sea.

In 2012, an additional sub-sample of 10 IDPs was interviewed about themes of social integration, social support seeking, and perceptions of community; since these interviews were more targeted, only one interview per person was carried out. Participants were compensated 15 lari (approximately US\$9) for their participation. These interviews were conducted with IDPs living in an urban collective center in Zugdidi, one which had not been visited in the earlier round, as well as with IDPs living in a compact settlement in Tbilisi. This second site was selected because key informant

interviews and data collected in Study 1 had suggested that there were differences in experiences of integration and community connectedness between IDPs in Zugdidi and Tbilisi. Given increased suspicions of IDPs in Tbilisi towards visitors, the study team obtained an introduction to the compact settlement population through a key informant in Tbilisi who has worked with this settlement community.

The interview guide was iteratively developed to accommodate and investigate new thematic material (e.g. local mental health constructs such as *batonebi*) and emerging theoretical constructs (e.g. role of social integration experiences). The guide was structured around broad domains of perceptions, behaviors, and experiences. These domains were identified based on reviews of the literature on mental health care-seeking and social support and were also developed to capture participants' particular life histories and contexts. Maxwell (2013) has written on structure in qualitative research designs, for example in terms of questions and guides. He argues that it is less important "*whether or to what extent you prestructure [sic] your study*"; more important is "*in what ways you do this, and why*" (p. 89). Further, Maxwell contends that while data collection may incorporate some structure, the data themselves may still be interpreted inductively. In this research, semi-structured interviews were utilized to meet practical restraints, but the data have been analyzed in an open-ended manner; this research considers data to be products of the research encounter but nevertheless reflective of participants' voices and experiences. From this constructivist perspective 'data saturation' can never truly be reached. However, data richness was sought, meaning whether enough information had been collected to sufficiently understand key concepts. Achieving data richness was important for "thick description" (Geertz, 1973)

of thematic categories and for developing theoretical constructs and a working Grounded Theory.

Interview modules for the 2011 sample examined participants': (Day 1), 1) introduction, 2) migration history, 3) conceptions of mental health and symptom recognition, 4) perceived need and social comparisons of distress, (Day 2), 5) role of household and social support systems, 6) care-seeking decision-making, pathways, and management, 7) conceptions of emerging local mental health constructs, and 8) experiences of formal mental health services. Interview modules for the 2012 sub-sample examined participants': 1) life in the community and social support seeking, including perceptions of community and social spaces, 2) services utilized, 3) connections to the past and views on the future, and 4) reactions to earlier findings (i.e. member checking). Questions and suggestions for prompts were provided as options within these modules to research assistants, but assistants were encouraged to participate actively in the interviewing process, to ask their own questions, and to move within the guide.

IDP participants were purposively sampled within collective centers using a maximum variation approach to represent different ages and both men and women. A chain sampling approach was also incorporated as IDPs were asked to identify other potential participants within their center; this strategy was used in combination with the maximum variation approach, for example by asking participants to identify men ages 60 and older. A maximum variation strategy provides a range of experiences and perspectives which is useful for investigating a given social process. The sub-sample of 9 IDPs was selected using a combination of chain and maximum variation sampling;

representatives at two mental health providers in Zugdidi, who were also key informants, were identified as seeds and were provided instructions for selecting potential participants. These individuals were then contacted by the study team.

Theoretical sampling was also utilized to follow new lines of inquiry and to gather data on emerging theoretical categories. Charmaz (1990) explains theoretical sampling as:

[Collecting] new data to check, fill out, and extend theoretical categories. . . Delaying focused theoretical sampling fosters gaining an in-depth understanding of the realities and issues at hand. Hence, theoretical sampling fits into the research and analytic process much later than initial sampling of sites, people, or documents. . . When developing formal theory and forming more generic concepts, grounded theorists take their substantive analysis from one area and conduct theoretical sampling in other substantive areas. (p. 1163).

Theoretical sampling was the impetus for carrying out the second round of IDP interviews in 2012. Initial analyses had demonstrated a link between social integration and care-seeking experiences, and further interviews were needed to explicate this further.

Screeners for Depression and Anxiety: The Hopkins Symptom Checklist 25 item screener for depression and anxiety (Derogatis, Lipman, Rickels, Uhlenhuth, & Covi, 1974) was administered to the sample of 39 IDPs in 2011. The screener was orally administered at the end of the first interview session. These data were not analyzed for this dissertation.

Field Notes: The author hand-wrote regular field notes during site visits and ethnographic observations, as well as reflective field notes after each key informant

interview. Typed field notes were also written about IDP interviews during debriefing sessions with research assistants.

Debriefing: A debriefing session was carried out with research assistants after each day of IDP interviews to summarize and reflect on interview content and the interview process. Debriefing allowed research assistants to provide their own reflections, which were incorporated into field notes, as well as to ask questions. During these sessions, the author provided feedback to research assistants about the interview process. Debriefing also allowed for the identification of key themes and illness episodes to follow up on during the second interview session.

Transcription and Translation

For Study 2, the primary translator transcribed interviews; for Study 3, research assistants transcribed the interviews that they themselves had conducted. Interviews were translated by several translators who were selected and provided guidelines by the author, including on identifying Georgian or Mingrelian idioms or culturally specific phrases and expressions as ‘in-vivo terms.’ Translators were native Georgian women who spoke English at an advanced level. The primary translator was from an IDP family, spoke Mingrelian in addition to Georgian, Russian, and English, and had studied in the U.S. for a year.

Data Management and Organization

The author maintained secured copies of data collection materials, including contact information forms for key informants and IDPs; no names were collected. The author also maintained secured copies of digital audio files and Georgian and English copies of transcripts.

Data Analysis

One of the primary aspects of Grounded Theory methods is that data collection and analysis is iterative and interactive, allowing for the development of theoretical constructs. In this research, the iterative process was limited given lengthy transcription and translation processes, the difficulty of making repeated visits to the same participants in this context, and logistical constraints. However, concurrent data collection and analysis occurred through ongoing interview guide development and adaptation, debriefing sessions, reviews of transcripts in the field, presentations of initial findings, and theoretical sampling. Writing field notes and reviewing transcripts allowed for immersion in the data and study context. This also led to an inductive bridging of themes and concepts directly grounded in the data and to the identification of a set of key themes, concepts, and patterns. After data collection was completed, transcripts were read through in full.

For Study 2, all transcripts from the 2012 sub-sample of 10 IDPs were selected for further analyses, which involved coding, memo-writing, category and construct development, and theory generation. Charmaz (2006) defines coding as “categorizing segments of data with a short name that simultaneously summarizes and accounts for

each piece of data” (p. 43). Saldana (2013) notes that coding is a cyclical process that allows for codes to be revised and segments of text re-coded. Selected transcripts were read and a combination of line-by-line and segment-by-segment open or initial coding (Charmaz) was carried out; this process also involved applying in-vivo codes to preserve participants’ phrasing. After open coding, an initial memo for each participant was written. These memos summarized each participant’s personal narrative, described contextual factors, explained key themes and topics addressed in the interview, and elaborated on open codes. The memos also included quotes associated with open codes, as well as interpretations of codes and emerging categories and patterns.

Coding and memo-writing are concurrent data analysis activities. Memos are a key part of the analysis process as they raise codes and quotes grounded in participants’ narratives to higher levels of abstraction: “coding is simply a structure on which reflection (via memo-writing) happens. *It is memo-writing that is the engine of grounded theory, not coding*” (Gordon-Finlayson, 2010, p. 164 as cited in Saldana, 2013, p. 52). Clarke (2005) writes that “Memos are sites of conversation with ourselves about our data” (p. 202). The memo-writing process allowed for the identification of key codes and emergent categories that were represented across transcripts. Focus coding was then carried out to develop these codes and categories further. Next, analytical memos were written for each emergent theoretical category or expanded code. Charmaz (2006) notes that emergent categories help explain and conceptualize data. Further memos were written to develop selected categories as higher-order theoretical constructs. Category and construct development was facilitated by the constant comparison of segments of interview text, codes, categories, and constructs to one

another. During the focus coding process, theoretical codes were also applied to segments of text to a limited extent, as the emphasis was on inductive coding; these codes drew on ideas within the critical frame employed in Study 2, which is Rosi Braidotti's (2011) nomadic theory.

After categories and constructs were developed, they were written out on index cards and sorted; this was an interactive and visual process that clarified relationships between categories. This process also provided an initial outline for the first draft of the research findings, which integrated the analytical memos: "Grounded theory sorting gives you a logic for organizing your analysis and a way of creating and refining theoretical links that prompts you to make comparisons between categories" (Charmaz, 2006, p. 115). The process of writing this draft further developed the emerging theory. Visual diagrams were also used to help conceptualize categories and their relationships.

For Study 3, transcripts from the 2011 sub-sample of 9 IDPs who had accessed formal mental health services were reviewed. Out of these, three participants' interviews were selected for inclusion within this analysis. Interviews were selected that were rich in narrative presentation and diverse in problems presented, type of mental health care sought, and recovery trajectories. This analysis was primarily concerned with describing care-seeking. Therefore, thematic description and analysis was prioritized over theoretical construct development. Dimensions of care-seeking (i.e. problem description, thresholds, timing, turning points, treatments, household and social support, and trajectories) were compiled into a matrix. This was done to facilitate categorization of data and to conceptually develop these dimensions. Selected interviews were open coded to allow for key emergent themes to be identified. Open codes and

associated segments of text were linked with dimensions within the matrix to construct each narrative. Wertz, Nosek, McNiesh and Marlow (2011) describe the importance of balancing texture, which “brings the fullness and richness of the experience to the reader” with structure, which “thematizes,” and identifies the boundaries of the phenomenon (p. 2). Interviews and open codes were also reviewed in light of constructs from the analysis in Study 2 in order to make broader statements about emergent patterns. This also allowed for a broader contextualization of episodes of mental illness or psychosocial problems.

Credibility

Making validity claims for interview data must reflect an understanding of the research encounter as co-constructed. Qualitative researchers often use terms such as the credibility and trustworthiness of findings instead of validity (Creswell, 2007). In this research, credibility is understood to be an indicator of whether findings are relevant, acceptable, and reflective of participants’ experiences. Credibility checks in Studies 2 and 3 involved: researcher reflexivity, member checks, expert checks, peer debriefing, theoretical triangulation, and cross-sample comparisons of constructs.

Researcher reflexivity was addressed through debriefing with research assistants, field note writing, and reflexivity memo writing during the analysis process. This allowed for the documentation of the author’s perspectives, values, and ideas throughout data analysis. One potential credibility threat that was revealed was the author’s earlier work in forced migration studies; familiarity with this literature might have primed the author to the concept of integration. Member checking involves sharing

findings with, and gathering feedback from, the participant population (Charmaz, 2006; Maxwell, 2013). Findings from the 2011 round of data collection were shared with the 2012 sub-sample of IDPs through member checking. This took place at the end of interviews by presenting participants with several key findings from the earlier interviews. Participants were asked to respond to statements about these findings. In addition, an unplanned form of member checking of the research process took place in the form of participant feedback on the experience of being interviewed and by extension, the usefulness of talking and sharing; while not all participants provided feedback, those that did were positive. For example, one participant said: “I, personally, am very happy that such things are conducted; so, that you are now conducting the studies, it’s a very good thing and I wish you success in everything and that you try to do good for us” (Study 2, IDP Participant 3). Another IDP participant, a 43 year old woman living in a collective center in Zugdidi, reflected on her first interview session and said that it had been helpful and interesting. She explained that she and other participants felt better after the interviews and that she should pay us rather than be compensated for the interview. She felt that talking about mental health, and reflecting on feelings and emotions, is helpful.

A limited form of expert checking was carried out during key informant interviews, as key informants were asked to respond to ideas and concepts that had developed in interviews with IDPs. Another potential credibility threat is that expert checking of the study conclusions in their current form has not yet been carried out, although this is an important next step. Peer debriefing occurred through the presentation of the study methodology and key findings to Georgian researchers during

several conference presentations from 2010-12, as well as to other peers at international conferences in anthropology, mental health and trauma studies, and forced migration studies. Key theoretical categories developed in Study 2 were found to be relevant to the narratives of participants in Study 3; although this was a limited process and needs further exploration, this cross-sample comparison of constructs was another credibility check. Analyses in Studies 2 and 3 involved examining disconfirming or contradictory evidence within and across participant narratives in light of codes, categories, and propositions. However, this research was limited in that it did not purposively sample negative cases to further develop theoretical constructs and thematic descriptions.

Another credibility check took the form of theoretical triangulation (Holloway & Brown, 2012; Maxwell, 2013), which involves applying different theoretical or disciplinary perspectives to the data; this was performed by considering findings within models of mental health recovery, mental health care-seeking, social integration, and nomadic theory. Maxwell also identifies detailed and varied data and intensive or long-term involvement in the study context as contributing to the credibility of a study. The author has made trips to Georgia since 2009 and spent a year living in Georgia from 2010-11. Interviews provided detailed information, but further research is likely needed to develop a more complete understanding of mental health care-seeking within the study population.

Chapter 3. Idioms of Distress and Everyday Problems among Older Adult Internally Displaced Persons in Georgia: A Qualitative Inquiry

Abstract

The global population of older adults (ages 60 or 65 and older) has been steadily growing due to demographic and epidemiologic transitions. However, little attention has been paid to the social and health needs of older persons, particularly within the developing world and among older migrants. This study was the qualitative research phase of an investigation assessing the health status of internally displaced older adults in Georgia. Field work took place between October 2010 and March 2011. The study aimed to qualitatively assess the kinds of problems older adult IDPs face, as well as the terms used to describe these problems. Free list interviews were carried out with 75 older adult long-term and 'new' IDPs in three regions of Georgia. Key informant interviews were carried out with 45 community members and service providers. Results demonstrated that older IDPs considered health and economic problems to be the most impactful. Access to health services was impeded by physical access challenges such as transportation, limited mobility, and isolation. Participants identified depression, stress and nervousness, isolation, passivity, and abandonment as key problems. Coping mechanisms included conversing and sharing with friends and family, giving and receiving advice, self-care, and working on plots. Findings suggest that strengthening social support systems, informal networks of care, health care access, and providing opportunities for engagement in the community may all be important for improving the well-being and functioning of older displaced persons.

Background

The global population of older adults (typically defined as ages 60 or 65 and older) has been steadily growing due to demographic and epidemiologic transitions within countries, with an estimated quadrupling of the global population 60 and over by 2050 (Bloom & Canning, 2004). According to the World Health Organization (2010), the proportion of the global population that is 60 years and older will double from 11% in 2006 to 22% by 2050. The rate of population ageing is the highest in the developing world, with projections that by the year 2050, almost four out of five people aged 60 or over will live in the developing world as opposed to two out of three in 2012 (United Nations Population Fund & HelpAge International, 2012). However, most of the research and services attention given to aging populations has been in high income countries, particularly on the effects of aging on nations' economies and the consequent growth of the migrant sector. Considerably less attention has been paid to the social and health needs of older persons, particularly within the developing world and among older migrants. The latter are often an overlooked and 'invisible' population in health research and programming for migrant and displaced persons. The existing literature on the health of older adult migrants highlights the importance of a focus on mental health outcomes, in terms of both social isolation and psychiatric disorder. There is a need for public health research that incorporates anthropological theory on aged migration in order to acknowledge the dynamic interaction between displacement, identity, social networks and mental distress and disorder. This study was a qualitative inquiry into the mental health problems and well-being of older adult internally displaced persons

(IDPs) in Georgia, with a focus on idioms of distress, experiences of displacement, and levels of functioning.

Aging in Displacement and Humanitarian Contexts

Anthropological and sociological theories of aged migration and aging in place are useful tools for framing an understanding of how migration processes shape mental health outcomes. In studying the interactive effects of aging and migration on health, it is important to move beyond linear causal pathways that isolate age as a predictor variable. Rather, the dynamic and reciprocal pathways between health and aging, migration histories, place, and social relationships must also be considered. Aged migration can be understood as the movement of migrants who are of an older age. Aging in place has been defined in numerous ways, but can be understood as the ability of older individuals to meet their social, physical and mental health needs in their current location. It can also be understood to refer to older individuals' ability to negotiate and remain in their current setting through the aging process (Cutchin, 2003; Lawler, 2001). Failure to achieve aging in place may result in out-migration. It is also possible to consider the aging process of migrants in their place of destination. Robinson has suggested the term 'aging in displacement' to capture this secondary process, or the effects of displacement on the aging process and health of the elderly (personal correspondence, May 2010). This concept is appropriate for the population considered in this study, who either began or continued the aging process in displacement.

Cutchin (2001) has critiqued behavioral approaches that model the process of migration as a discrete event separate from larger life contexts and experiences. The displacement and integration processes of older IDPs are shaped by complex life events. Similarly, the experience of ‘aging in displacement’ is not only shaped by displacement. Aging in place, or in displacement, involves exerting one’s identity onto place and simultaneously drawing upon one’s relationship to one’s past residences. Rowles (1983 as cited in Cutchin) suggests that the elderly have an intimate, phenomenological attachment or ‘insideness’ to physical place, which allows the elderly to relate to, and draw meaning from, place. The relationship that older displaced adults have to place, both to past and current residences, however, is interrupted, uncertain, and disconnected. This interrupted relationship affects social experiences and perceptions of belonging. Cutchin argues that a pragmatic approach complements a phenomenological one, as it recognizes that older adults are part of, and interact with, a broader social context. A pragmatic perspective suggests a focus on the problematic features of older displaced persons’ current environments, in addition to subjective experiences of migration and integration. As Cutchin writes: ‘At some time, aging bodies and minds, place or the relationship between elder and place becomes problematic’ (pg. 39).

Older adults face unique vulnerabilities and risks to health in humanitarian and displacement contexts. Older adults who have chronic illnesses, physical disabilities or limitations, cognitive deficiencies, and limited social supports, will face challenges in meeting basic needs in nutrition, clean water access and transport, and shelter (Burton & Breen, 2002; Fernandez, Byard, Lin, Benson, & Barbera, 2002; Kohn, Levav, Garcia, Machuca & Tamashiro, 2005). This is particularly the case in initial stages of an

emergency when social networks are compromised and resources are limited (Burton & Breen). These limitations and the particular needs of older populations in emergencies are often overlooked by aid agencies and their programs. Burton and Breen present the example of relief programs that require refugees to construct their shelters themselves with limited materials; this approach may be useful for self-reliance objectives but becomes an additional health and social risk for older persons who have limited physical functioning. Further, older displaced adults, who may be more likely to have chronic illnesses, face challenges in accessing health services and a regular supply of medications (Burton & Breen; Fernandez et al.). Older adults must also contend with unique social losses and the mental health, distress and psychosocial sequelae of conflict and displacement (Burton & Breen; HelpAge International, 2000; Kohn et al). Loss of homes, property, and social networks may have greater effects on older adults given a stronger attachment to places of origin. Older adults may have a harder time adapting to new communities, as well as fewer opportunities for engagement in economic activities and social networks (Burton & Breen). In addition, older adults who have impaired physical mobility, are house bound, or socially isolated, will be more limited in their ability to respond to, and recover from, a disaster. Frailty is not necessarily determined by older age, but rather by the association between older age and the likelihood of having particular vulnerabilities. Further, there are a range of dimensions that contribute to frailty or vulnerability in older adults during disasters, such as physical impairments, pre-existing medical conditions, social impairments, and financial vulnerability (Fernandez et al.).

Aging and Mental Health

Older displaced adults face many of the same cognitive and psychiatric disorders that the general older population does, including dementia, Alzheimer's, late-life depression, as well as generalized distress and demoralization. Older adults also share vulnerability to similar risk factors, including physical disability and immobility, social isolation, changes in social networks, and economic instability. The gerontological literature presents two competing perspectives regarding risk for psychological distress. The differential vulnerability hypothesis suggests that the elderly have more risk factors and are at higher risk for distress. The findings from several studies of elderly migrants are suggestive of this hypothesis (Chou, 2007; Koochek, Montazeri, Johansson, & Sundquist, 2007; Lerner, Kanevsky & Witztum, 2008; Patel & Prince, 2001; van der Wurff et al., 2004). The maturation and inoculation hypotheses suggest that the elderly are more resilient due to, respectively, older age and experience and are thus at lower risk for distress. There is limited empirical evidence that allows for mechanistic claims to be made about how risk for distress may increase among older migrants and whether migration alone or the combination of migration and advanced age increases risk for distress.

Major Depressive Disorder (MDD) has been found to occur in at least 1% - 4% of the general older adult population in high income country settings (Blazer, 2003; Cole, Bellavance, & Mansour, 1999; Frederick et al., 2007; Gellis et al., 2008). Further, 8% - 16% of the older adult population has been found to have sub-threshold symptoms of depression or minor depression (Cole et al; Frederick et al.; Gellis et al). More than a quarter of older adults with sub-threshold depression develop MDD within three years

(Speck et al., 2007). While rates of MDD decrease with older ages, rates of depressive symptoms and suicide increase (Gallo & Lebowitz, 1999 as cited in Barg et al., 2006). However, when factors associated with older age, such as increased physical disability, cognitive impairment, and lower socio-economic status (Blazer, 2000; White, Blazer & Fillenbaum, 1990; All: as cited in Blazer, 2003) were controlled for, no relationship between depressive symptoms and older age was demonstrated (Blazer, Burchett, Service & George, 1991 as cited in Blazer, 2003).

There is inadequate detection and treatment of depressive symptoms among older adult populations (Cole et al., 1999). Recognition of sub-threshold depressive symptoms among older adults is complicated by physical immobility, being home-bound by medical illness, social isolation, and presenting primarily with somatic symptoms (Gellis et al., 2008). A study (Barg et al., 2006) of older adults with and without depression as measured by the CESD scale found that older adults have a tendency to describe depression in terms of experiences of loneliness, including during encounters with primary care providers. This affects older adults' tendency to seek out specialized mental health care and accept diagnoses of depression. Further, the study also found that older adults viewed loneliness as an expected outcome of aging and an outcome of social withdrawal, in addition to being a precursor to depression.

Late-life depression has been increasingly understood to be an experientially distinct category of clinical depression, including sub-types such as major depression, minor, subsyndromal, or subthreshold depression, and depression co-morbid with other mental and physical diseases (Barg et al., 2006; Blazer, 2003). Among community dwelling older adults, studies have demonstrated an association between late-life

depression symptoms and decreased quality of life (Blazer), as well as between depression and loss of functionality, as mediated by cognitive deficiencies (Gallo, Rebok, Tennstedt, Wadley, Horgas et al., 2003). Late-life depression has been linked to increased use of hospital and outpatient care in U.S. based populations (Huang et al., 2000; Luber et al., 2001; and Unutzer et al., 1997; All: as cited in Blazer).

The limited literature on older adults in low income countries suggests that these individuals face particular risks for poor mental health outcomes given economic and environmental stresses, such as urbanization, poverty, war, and displacement, as well as changes in family care structures and limited health service access (Levkoff, Macarthur, & Bucknall, 1995). Kohn et al. (2005) found that older adults in Honduras who were exposed to a major hurricane had high scores on measures of post-traumatic stress disorder (PTSD), suggesting vulnerability to traumatic stress. However, they found no significant differences in scores on measures of PTSD, depression, and alcohol between older and younger adults. Among refugees, older age has been found to be associated with higher levels of PTSD symptoms (Weine et al., 1998). Weine et al. assessed PTSD symptoms among Bosnian refugees in the United States, at resettlement and at follow-up one year later. At both time points, older age was found to be associated with significantly higher levels of distress, compared to other age groups. In addition, older refugees have been found to have higher levels of psychological distress compared to other types of migrants. This suggests that exposure to forced displacement increases risk for distress among older populations. Chou (2007) found an overall increase in distress (as measured by the GHQ-12) over the course of one year of residence in Australia among immigrants aged 50 and older. Refugee status was associated with

higher levels of distress compared to other types of migrants, controlling for other predictors. Chaaya, Sibai, Fayad, and El-Roueiheb (2007) surveyed older adults living in poor urban areas in Lebanon, including older Palestinian refugees living in a camp setting. They found significantly lower odds of depression (as measured by the GDS-15) among older refugees who regularly attended a mosque. Chaaya et al. suggested that organized practice of religion may be a particular coping mechanism used by older refugees and may provide protective effects through mechanisms of social support and solidarity or sense of belonging.

Research Design and Methods

Study Context

A significant proportion, approximately 25%, of IDPs in Georgia is aged 60 years and older (Zoidze & Djibuti, 2004). This study was the initial, qualitative research phase of an investigation assessing the health status of internally displaced older adults in Georgia, entitled: 'Aging in Displacement: Assessing Health Status of Displaced Older Adults in the Republic of Georgia.' The investigation was run by the Johns Hopkins Center for Refugee and Disaster Response with a local partner, the Institute for Policy Studies. The investigation comprised three phases: qualitative inquiry, instrument development and validation, and a prevalence study, as well as a small case study of Chechen refugees. Field work for all aspects of the investigation took place between September 2010 and August 2011. The primary objectives of the investigation

corresponded with each of the three phases: 1) First to qualitatively assess what kinds of problems older adult IDPs were facing, as well as the terms and idioms that were used to describe those problems; 2) Second, to develop and validate locally adapted measures of a range of health and functional outcomes; and 3) Finally, to collect household survey data on health and demographic indicators.

This investigation was designed as a mixed methods study with each phase actively informing the development of subsequent phases. The first phase was designated as the qualitative inquiry in order to collect in-depth information about the study site and context and to facilitate the development of a locally relevant survey instrument. The qualitative study sought to describe problems facing older adult IDPs across Georgia at the individual, household and community levels. It also sought to elicit local terminology used to describe psychological problems, local mental illness constructs, and local modes of functioning. The perspectives and experiences of both older adult IDPs and knowledgeable community informants were collected. Fieldwork for the qualitative study took place between October 2010 and March 2011 and was carried out in three study regions across Georgia: Samegrelo, Shida Kartli, and Tbilisi.

Ethics Review

The study protocol, consent forms, and instruments were reviewed by U.S. and Georgian institutional review boards in accordance with standard research procedures. These IRBs are located at the Johns Hopkins Bloomberg School of Public Health in Baltimore, U.S. and the National Center for Disease Control and Public Health in Tbilisi, Georgia.

The study was granted permission to proceed before data collection commenced. Data collection procedures were also reviewed with Georgian staff at the local collaborating research organization to ensure that the protocol and data collection instruments were locally appropriate.

Field Interviewers

The local collaborating research organization for this study was the Georgian NGO, Institute for Policy Studies (IPS), based in Tbilisi. A team of six field interviewers and one field supervisor (all female and Georgian) employed at IPS were trained in the study protocol over the course of several days by the author. Although all interviewers were experienced in qualitative research methods and interviewing, the training also involved a review of qualitative interviewing techniques and particularly focused on the method of free listing. Interviewers also had significant experience in research with displaced communities.

Study Methods

This study utilized a qualitative research design to investigate older adult IDPs' experiences of mental health problems and displacement. Qualitative methods are useful for research that investigates meaning, identity, and social processes (Morse, 2011). Cutchin (2001) and Rowles (1983) advocate for qualitative methods as a means for accessing the relationship between migration and aging. Qualitative methods, including semi-structured interviews and free-lists, are also effective methods for

eliciting illness narratives, local idioms of distress, as well as ethnomedical terms and knowledge (Kohrt & Hruschka, 2010).

The study utilized the linked methods of free list and key informant interviews. This methodology was adapted from an approach that has been employed and validated in numerous studies on global mental health topics, including among street-children in Georgia (Murray et al., 2012). This approach has been particularly useful for instrument adaptation and validation studies (Bass, Ryder, Lammers, Mukaba, & Bolton, 2008; Bolton & Tang, 2004). Qualitative and textual forms of data collection are important for survey research as they contribute to the local adaptation of standard measures and also allow for more nuanced interpretations of survey data. The often ill-defined parameters of mental illness constructs across settings and the extent to which these constructs are influenced by context requires that they be measured using indicators and terms that are consistent with the study setting. This, in part, means moving beyond the simple translation of measures to adapting wording and adding indicators in order to integrate local interpretations and experiences of mental health, illness, and functioning. An approach that is open-ended, flexible, and emphasizes narrative expressions of experiences is particularly useful for navigating potential differences and discrepancies between standard psychiatric and ethno-psychiatric definitions of mental health and illness.

This approach of combining free list and key informant interviews is broadly characterized as ‘qualitative.’ However, free listing is more accurately described as a form of systematic data collection (Weller & Romney, 1988). Free listing has its origins in cognitive anthropology, and its primary purpose is to textually map individual

cognitive domains. That is, free list interviews aim to identify all items, or ‘included terms,’ that belong to a given category or cognitive domain. This is accomplished by asking respondents a primary question, which typically is to list all instances of the category of interest that respondents can call to mind. Secondary questions may be included to collect further details about this category. Free list data can be analyzed both qualitatively, through the identification of key themes, the relationships between them, and the words used to describe them, as well as quantitatively, through frequency calculations of listed items. Frequency calculations provide information on the extent to which respondents believe that certain items ‘belong’ to or make up the given category. It is useful to examine how often items are mentioned because this can indicate the extent to which certain topics or problems are readily accessible and thought about in a community. However, items may be infrequently mentioned because they relate to a sensitive topic or to topics that are difficult to list as distinct items and may retain significance and warrant further investigation. In this study, free listing was essential for instrument adaptation purposes, as it allowed for the efficient and clear identification of many important problems for the community, including local constructs of health and functioning.

In-depth interviews are often utilized in conjunction with free list interviews, as they provide more textually rich data and are useful for contextualizing, elaborating upon, and interpreting free list data. Interviews may also be useful for identifying local categories to enquire about during free listing. Understanding the mental health status and needs of older adult IDPs was a key objective of the larger investigation. Key informant interviews were used to gather in-depth information on themes from the free

lists that specifically referred to mental health or psychological problems. These themes did not tend to be frequently mentioned, perhaps given the sensitive nature of mental health topics. The key informant interviews provided the opportunity to learn more about mental health problems and how they were talked about from the perspectives of knowledgeable community members.

Data Collection

Free list interviews were made up of five questions. Question 1 was intentionally framed as a broad, open-ended question to elicit a wide range of responses and to find out what community members themselves considered important problems. Questions 2-5 were follow-up questions that were intended to gather data on how respondents related to others, particularly their families, as well as on how well they were able to function and carry out daily activities. Finally, participants were asked to recommend community members who were knowledgeable about the problems facing older adult IDPs.

6. What are the major problems that displaced older adults (ages 60 years and older) have?
7. What are the major problems displaced older adults have that affect their families?
8. What routine tasks do displaced older adults do to take care of themselves?
9. What routine tasks do displaced older adults do to take care of their families?
10. What routine tasks do displaced older adults do to participate in the community?

Free list and key informant interviews were sequentially carried out in each study region. Data collection trips were jointly coordinated and supervised by the IPS field supervisor and the author. Free list questions were compiled onto a free list form. Free list interviews lasted approximately 45 minutes. The interviewer posed each question and asked the respondent to list his/her responses. When the respondent had completed

listing responses for a given question, the interviewer moved on to the second question. Interviews were conducted by pairs of field interviewers, with the first interviewer posing the questions and the second taking detailed hand-written notes of responses. None of the interviews were digitally recorded, and all were conducted in Georgian.

In order to identify important content areas to follow up on in the key informant interviews, data from free list forms were entered into Excel spreadsheets and coded for summary themes that represented each listing. Frequency calculations were run on these themes. Frequencies, themes, and detailed content were reviewed by the study team to identify themes and responses that specifically had to do with mental health or psychological problems and which seemed to hold significance within the study population. Selected themes for key informant interviews differed slightly across study sites, depending on what free list responses were given in each. The selected core themes for each study region are listed in Table 3.2.

Key informant interviews in each study region were carried out three to four weeks after free list interviews were completed. The key informant interview involved inquiring about associated thoughts, feelings, and behaviors for each selected core theme. Examining this phenomenological triad is essential for diagnosing mental illness in clinical settings and as such, is also useful in research settings for uncovering and describing mental health problems from multiple angles. Key informant interviews lasted approximately one hour. The interviewer posed each question and allowed the respondent to answer; the interviewer then asked additional probing questions to gather more in-depth information. Once again, interviews were conducted by pairs of field interviewers in Georgian and were not digitally recorded.

Trustworthiness of data collected was established through several procedures. First, feedback from IPS staff was regularly solicited and gathered before and during the data collection process to ensure the study protocol was locally appropriate and to inform the development of interview questions. Reflections with field interviewers were regularly carried out after data collection trips to gather interviewers' feedback on the data collection process, insight into the study population and context, and initial interpretations of interview data. Survey data from the later phases of the investigation allowed for comparisons of key findings using different data collection methods. The study methodology and findings were presented in several forums in Georgia and the US, including to a Georgian audience comprised of policy-makers, local researchers, and selected study key informants.

Study Sample

In total, 120 respondents were interviewed in the study, including both free list and key informant interview respondents. Characteristics of study respondents are listed in Tables 3.1 and 3.2. All respondents were sampled from rural/ peri-urban and urban sites in the three study regions of Samegrelo, Shida Kartli, and Tbilisi. Free list interviews were carried out solely with IDPs. The following inclusion criteria were used for free list respondents: 1) IDPs from either the new or the old case-load; 2) Residing in one of the three study regions; 3) Aged 60 and older. Respondents from Tbilisi and Zugdidi were all from the old case-load, whereas respondents from Shida Kartli were from both case-loads, but primarily the new. IDPs living in all settlement types were sampled, including private accommodation, collective centers and compact settlements

(both state and privately owned), and new settlements. With the assistance of local service organizations that worked with IDP communities, respondents were purposively sampled in order to represent both sexes, different ages within the target age bracket, locations, and settlement type. In total, 75 free list respondents were interviewed, with 25 respondents per study region.

Key informant interviews were carried out with a range of community members who were identified as being knowledgeable about issues concerning older adult IDPs. Key informants were not restricted to any social or age group. Inclusion criteria were: adult community members who were 1) residing and/or working in one of the three study regions and 2) knowledgeable about issues of concern to older adult IDPs. Key informants were selected from all three study regions, from both urban and non-urban sites. Key informants were both IDPs and non-IDPs, and included community leaders, government representatives, lawyers, NGO workers, doctors, psychiatrists, and social workers. Key informants were purposively selected based on recommendations made by free list respondents during interviews and by IPS senior research staff familiar with service organizations in the study sites. In total, 45 key informants were interviewed, with 15 informants per study region.

Data Analysis

Initial data analyses took place while data collection was ongoing. During data collection periods, interviewer pairs regularly reviewed their written notes with each other and the rest of the field team. Interviewers also shared their initial interpretations of responses during group reflection meetings that occurred after each site visit. Interview data were

initially rapidly analyzed in the field by the local team and were then reviewed by the rest of the study team. Analysis involved the simultaneous entering and coding of textual interview data using standardized Excel forms. When applying thematic codes to interview text, an attempt was made to both summarize the text and to represent key phrases and terms that were used in that text. English translations were subsequently added into the forms. Since the free list interviews collected data as separate items, it was straightforward to enter them as separate text segments. Entering text from the key informant interviews involved systematically isolating segments of text that corresponded with categories of perceived cause, symptoms/signs, associated problems, and coping mechanisms. Frequency calculations were then run on the thematic codes that corresponded with segments of text. Subsequent analyses took place on-site at JHSPH by the author. This involved reading through all responses with a focus on the context surrounding specific themes and the connections respondents made between different themes. Analysis was designed to produce a comprehensive and detailed description of key problems and constructs in a manner that was straightforward, clear, and easily communicable to community members, practitioners, and policy-makers.

Findings: Key Problems and Idioms of Distress

Overview of Problems

An examination of free list responses across all three study regions demonstrated that the most salient problems for IDPs had to do with health problems, health care access, and economic conditions (See Table 3.3). These problems were often linked, for

example, IDPs often spoke about not having enough money to pay for medicines to take care of chronic health conditions. ‘Health problems’ was the most common theme, or problem category, across all three study regions. This category mostly included the listing of specific illnesses or conditions, but also included general statements about pain or health concerns. The next top problem category had to do with health care access, including not having enough money for medicine and not having health insurance. The remaining top problem category across regions had to do with economic problems, including having a ‘small pension,’ ‘unemployment,’ a ‘lack of money,’ ‘high taxes,’ and not being able to ‘afford firewood or electricity for heat.’

Notably, among these top categories that had to do with very pragmatic issues were two themes that had more to do with personal feelings and sentiments: the ‘indifference of others towards IDPs’ and a ‘desire to return to Abkhazia/ Ossetia.’ The unique experience of being an IDP, versus simply the effects of living in displacement and difficult circumstances, was therefore prominent in the minds of many IDPs. Indeed, in Tbilisi, the theme of ‘indifference of others towards IDPs’ was more frequently applied to the data than any theme having to do with non-health related economic problems. This theme, outlined in greater depth below, included many statements about the level of government concern for IDPs. It is likely that this problem was more salient for respondents in Tbilisi than in other cities because Tbilisi IDPs live in greater proximity to the central government and its activities, because these IDPs are often less integrated with the local non-IDP population, and because of the government evictions of IDPs from collective centers that took place in the summer of 2010 and early 2011 (Amnesty International, 2011). As one free list respondent in Tbilisi explained: ‘No one remembers

us. We do not exist. No one asks about us. Nobody comes, nobody wants us. They only remember us before the elections' (IDP, Tbilisi, long-term, urban collective center, female, age 63).

Health Problems

'Health problems' was the most frequently mentioned problem category; this category was then broken down into types of problems. Most of the physical health problems that free list respondents listed across sites were chronic and had to do with limited mobility and physical functionality; many of these problems are associated with older age. In Tbilisi and Shida Kartli, mobility problems were the most frequently mentioned problems; in Samegrelo, they were the second most frequently mentioned. Mobility problems included problems such as being unable to, or having difficulties with, moving, getting up, standing, walking, and running. Respondents also described other functionality problems with their legs, arms, and hands, such as having 'sore feet,' 'sore legs,' 'swollen legs,' 'paralysis,' as well as 'sore joints,' 'pain in fingers,' and 'arthritis.' One free list respondent in Samegrelo described a fall she had: 'I could not move for eight months, I fell down on my way to the bathroom and broke a bone. It's the third year since I feel pain in my back, and my feet are insensitive, like a wooden stick' (IDP, Samegrelo, long-term, urban collective center, female, age 75). The top health category in Samegrelo was blood pressure problems, and this also appeared as a key theme in the two other study regions. The second most frequently mentioned health category in Tbilisi and Shida Kartli was diabetes or 'blood sugar problems.' Other top problems were problems of the digestive system, such as gallbladder problems and hernias, vision

problems such as cataracts, heart problems, such as heart attacks and arrhythmia, arthritis, sore joints, and ‘other limb problems.’

Health Access Problems

Problems related to health care access that were listed across sites had to do with not having enough money for medications, having no or insufficient health insurance, expensive medical treatments and ineffective medical treatments. IDPs talked about not being able to pay for the medicines that they knew were necessary for treating and managing their often chronic health problems. For example, one respondent in Samegrelo explained that ‘I visit the doctor, but I cannot buy the medicine’ (IDP, Samegrelo, long-term, urban collective center, female, age 61). Another respondent in Shida Kartli said that he had taken some medications in the past but now he avoids visiting the doctor since he cannot afford them: ‘I bought and drank medications then, and after that I haven’t gone to a doctor. My pension is not enough for medications anyway’ (IDP, Shida Kartli, new, rural settlement, male, age 83). In Tbilisi, listings within the category of ‘no health insurance’ included problems such as not having insurance coverage for specialist care or screening and diagnostic tests. In their descriptions about inadequate insurance coverage, IDPs also mentioned problems with the availability of, and geographic access to, services: ‘Every doctor denies taking me as a patient’ (IDP, Tbilisi, long-term, urban collective center, female, age 63); ‘I have heart ischemic disease, growing pains, and stones in kidneys and I have insurance, but the clinic is very far and I cannot go there’ (IDP, Tbilisi, long-term, urban collective center, female, age 72). In Samegrelo, IDPs described not being able to pay for expensive

medical treatments such as eye and heart surgery. Problems having to do with ‘ineffective medical treatments’ were not as frequently mentioned as those in other health access categories, but included medicines not helping or causing further problems because of side effects, dirty hospitals, stories of patients who died because of negligence, and doctors who did not understand their problems. For example, one respondent in Shida Kartli explained: There are no good doctors. I have one problem and they give medications for another. I went to a doctor and he just told me I was old. He nearly said ‘what else were you expecting? What else do you want?’ I got very nervous’ (IDP, Shida Kartli, long-term, urban collective center, female, age 76).

Economic Problems

In addition to high costs of medications and treatments, IDPs also described a number of other economic problems, including having a ‘small pension,’ ‘unemployment,’ a ‘lack of money,’ ‘high taxes’ and ‘affording firewood or electricity for heat.’ Having a ‘small pension’ was a top problem across all study regions. Respondents repeatedly explained that their pensions were simply not enough to pay for various expenses and to help support their families: ‘Our pension is a laughingstock. I get 100 laris [a month] and 50 are spent on medications’ (IDP, Tbilisi, long-term, rural collective center, male, age 77). In Shida Kartli, another respondent said: ‘Pension is not enough. What can I buy on it? I need food and medicine--I don’t know whether I should buy one or the other?’ (IDP, Shida Kartli, long-term, urban private accommodation, male, age 80). Another respondent in Tbilisi commented on the insult of having a small pension after many

years of service to the government: ‘I get 92 laris. I had to go to the court to get more 7 laris. They say I had to have 25 years length of service. I have 21. I am 4 years short. I have no nerves to go to the court. This government insulted me’ (IDP, Tbilisi, long-term, rural collective center, female, age 60).

‘Unemployment’ was a significant problem category across all three regions for both older IDPs and their adult children and grandchildren. Some IDPs described the irony of working for years but not being able to find a job now, while others talked about how having a higher education no longer guarantees a job. One man explained that work had the potential to distract him from his everyday problems, but he was not able to find any. Unemployment not only kept IDPs focused on daily troubles, but it also affected their overall well-being and sense of hope: ‘The unemployment of our children and the fact that we also are jobless has a very bad effect on our morale. It is highly unpleasant’ (IDP, Tbilisi, long-term, rural collective center, female, age 60).

Living Conditions

No running water, electricity or firewood, cramped living quarters, and leaking roofs were some of the problems with living conditions that IDPs described. Most of these responses were given by IDPs living in settlement types other than private accommodation, including collective centers that were privately owned. ‘Poor living conditions’ was a salient problem category in Tbilisi and Shida Kartli; in Samegrelo, it was the second most frequent category. IDPs in Samegrelo talked about having cold and damp rooms, leaking roofs, and having to carry water up flights of stairs from outside because of no running water. In Shida Kartli, respondents also talked about having

heating problems such as no gas or not being able to afford an electric heater. In Samegrelo, heating problems was a salient enough issue that it became a separate problem category. A couple of respondents noted that they could not afford to buy firewood; others said they could not afford electricity. IDPs also talked about how hard it was to live in small living spaces, particularly when many family members lived together in one room. Respondents in all regions talked about waiting for the government to make repairs in collective centers and about broken promises from the government: ‘We have no gas and it’s very hard. We want them to build a gas pipeline, but no one cares. They promise us, but those are only words’ (IDP, Shida Kartli, new, urban private accommodation, female, age 78); ‘They promise to fix, but nobody cares. The time passes and nothing is done, the situation with IDPs is like a tale’ (IDP, Samegrelo, long-term, urban collective center, male, age 68).

Displacement Related Problems

Free list respondents named a number of problems that had to do with their status as IDPs or life in displacement. Similar displacement related problems were named across the three study regions (See Table 3.1). Notably, the top listing in Tbilisi was ‘indifference of others towards IDPs.’ With 13 listings, this was the most frequently mentioned displacement related problem across all of the sites. As previously mentioned, it is likely that living in the capital city and near government agencies, as well as hearing of the regular evictions that had been taking place in the city, contributed to this sense of abandonment from the government. It is also possible that IDPs in Tbilisi experience more segregation because of greater economic disparities in

the capital city. Finally, older IDPs in Tbilisi who grew up in Abkhazia might experience greater social and cultural distance from local Tbilisi residents; one respondent described feeling like an ‘outcast’ (IDP, Tbilisi, long-term, urban private accommodation, male, age 63).

Tbilisi was the only site where one respondent described dissatisfaction with the integration process: ‘The integration process is very bad. One can sit in the house for the whole day. One can’t contact anybody. One has no job and cannot communicate with others.’ (IDP, Tbilisi, long-term, urban private accommodation, male, age 63). However, integration was mentioned by key informants as a perceived cause of the psychological problems: ‘Nervousness,’ ‘Nothing makes me happy,’ and ‘Having nothing to do.’ A sense of social distance from their communities may heighten IDPs’ feelings of frustration with their living conditions, status, and the government. Although it was not mentioned as often in Shida Kartli and Samegrelo, IDPs in these sites also frequently mentioned feeling abandoned, ignored, or indifference from others. In addition, not owning or having living spaces, as well as a desire to return to Abkhazia/ Ossetia were top categories across regions. In Tbilisi, a couple of respondents explained that they could no longer visit family graves in Abkhazia. In Shida Kartli and Samegrelo several respondents explained that not having access to land, plots or gardens was a real problem because it prevented them from being able to work, make a living, and grow their own food. Other displacement related problems included problems with documentation, registration for pension, and not owning living space.

Mental Health Problems

A range of psychological and mental health problems were also described, although these were less frequently mentioned (See Table 3.1). An examination of the words used by free list respondents and the types of experiences described suggests that responses across sites can be grouped into two constellations of feelings: 1) sad or depressed mood and 2) worried or anxious mood. These constellations, as well as how individuals experienced these feelings, appear to map onto clinical definitions of depressive and anxiety states. However, while this qualitative inquiry generated this observation, it does not allow for a conclusion to be made about how valid clinical constructs are for categorizing respondents' experiences. Rather, it suggests that these constructs are closely paralleled by the local idioms of distress expressed by Georgian IDP respondents.

IDPs in both Tbilisi and Shida Kartli used the Georgian words for 'depressed' (დეპრესიაში/ depresiashi) and 'depression' (დეპრესიის/ depresiis) to describe their own or family members' emotional states. For example, one woman explained: 'I am a bit of a depressed person have and this makes my situation worse' (IDP, Tbilisi, long-term, rural collective center, female, age 60). No prompts were given during the free-list interviews. These respondents, therefore, were aware of and chose to use these terms to describe their feelings. However, it is not clear whether or not they were aware of or identified with the psychiatric construct of depression. Still, it is noteworthy that the symptoms respondents described when talking about feeling depressed map onto clinical definitions of depression. These symptoms included feeling bad, no longer being

able to find enjoyment in activities, crying all the time, not having the energy to get dressed, and difficulty in planning or carrying out activities:

I am depressed, sometimes I am even lazy to put on my clothes. Yes I have physical problems, but I don't like Gori as well, I cannot get used to living here. Yes, I do all the house chores and I was very active before, but these few years have been hard for me. If I have to go somewhere I start preparing two to three days beforehand (IDP, Shida Kartli, long-term, urban private accommodation, female, age 64).

One IDP in Tbilisi also talked about feeling hopeless about the future; this again could be indicative of an overlap between a psychiatric depression construct and the depression-like experiences described by respondents. In Samegrelo, IDPs did not use the terms 'depressed' or 'depression' explicitly. However, one individual described feeling 'strained' and said that 'nothing makes me happy.' Others talked about feeling 'tormented' and lonely.

Key informant interviews provided further detail on what these feelings involved and what might cause these feelings among older IDPs. Key informants in all study regions were asked to speak more about the feeling of 'nothing makes me happy.' In Tbilisi and Shida Kartli, key informants primarily attributed this feeling to living in difficult circumstances. Other perceived causes included not having money, problems with local integration, the losses experienced because of displacement, being isolated, and not being able to work. In Samegrelo, informants explained that older IDPs often have nothing to do, feel hopeless about return, feel disrespected, and have many health problems; these experiences could contribute to despondency and despair. Informants also provided information on the types of coping behaviors that older IDPs used in response to psychological problems. Informants explained that talking about and

sharing their problems was a common way for IDPs to deal with feeling unhappy.

Informants across sites also noted that older IDPs feel a sense of helplessness about attending to their happiness or that they cannot, in fact, help themselves. Relationships with family, particularly children and grandchildren, were also said to help older IDPs.

IDPs also spoke frequently about feeling nervousness or experiencing ‘nerve problems.’ In Tbilisi, IDPs described worrying about their adult children, thus demonstrating a strong sense of interconnectedness among family members. In Shida Kartli, respondents talked about feeling nervous, fearful, and having nightmares. One IDP explained:

I was a newspaper editor. . . I had a three story house. I started a newspaper with other refugees and I was an editor for 15 years, then they shut it down. I suffered a lot for it. Now it is in business again and I want to work. I work and it keeps me alive. I go back there, to Tskhinvali, in my thoughts. I analyze what happened there, why it has happened. These thoughts and fear is the worst thing for me. We have no money problems. But the moral condition is bad. I cannot watch TV anymore. I read newspapers, but lately it is causing nerve problems as well (IDP, Shida Kartli, long-term, urban private accommodation, male, age 78).

The newspaper was thus reminder of the life this man once had, the past he longed for and the future he felt he could no longer have. The newspaper was both a trigger for nervousness and repeated thoughts of the past and a symbol of his nostalgia. Ultimately, however, he points to the negative thoughts and his fear as ‘the worst thing.’

Key informants in all study regions were asked about ‘feeling nervousness,’ and they primarily attributed the feeling to problems with money, unemployment, and inability to access health services. Informants also spoke about how feelings of worry, anxiety, and stress were tied to experiences during the war and in displacement, for example: war trauma, remembering the past, grieving what was lost, difficulty adapting to new

environments, inactivity, being evicted from homes, and a desire to return. Informants explained that older IDPs coped with nervousness and stress by providing support to one other and by receiving support from neighbors and family members. Thus, social support had the potential to be healing not only when it was received but also when it was provided. Working on plots, trading and other income-generating activities, as well as inter-personal communication such as conversing were other behaviors that helped with nervousness.

Another important set of feelings and experiences that emerged from the free list interviews had to do with feeling abandoned, forgotten about, and alone. In Tbilisi, key informants provided more information on why older IDPs experienced ‘feeling abandoned’ and ‘feeling isolated.’ Informants attributed a sense of abandonment to a lack of attention and support from the government. To cope with this, IDPs instead turned to friends, relatives, and at times, to themselves. However, informants also explained that families do not always support their older relatives, and that older IDPs lack strong social ties. Some older IDPs do not receive support from anyone and are not able to help themselves. The problem of feeling isolated had similar perceived causes and coping behaviors, but informants also attributed this feeling to problems with local integration, experiences with negative attitudes from the local population towards IDPs, and thinking that society does not need them. Key informants in Shida Kartli were asked to discuss the problem of feeling a ‘lack of concern’ from others. This feeling was linked to both the larger community and to their families. Feeling that nobody needs them, a lack of attention from the government, living apart from their children, having health problems, tensions with the younger generation and remembering the past were all

associated with experiencing a lack of care and concern. To cope with this, older IDPs talked with others and shared their problems, worked on their plots, and took care of their children. Once again, some informants said that older IDPs cannot do anything to resolve this feeling.

In Shida Kartli, key informants discussed the problem of older IDPs having ‘nothing to do.’ This problem was attributed to a lack of jobs, being alone, problems with local integration, as well as living in cramped spaces where there is not enough room to engage in activity. Key informants described the effects of having nothing to do as including missing the past, worrying, insomnia, having negative thoughts, and having health problems. Coping behaviors included talking to each other and sharing problems, getting involved with programs and initiatives, working on plots, and receiving help from neighbors and family members.

Another key area of inquiry had to do with how older IDPs described relating to their families. Free list responses included descriptions of quarrels and arguments with family members, as well as descriptions of older IDPs feeling like they were a burden to their families. Key informants in Samegrelo were asked about both of these experiences. The problem of ‘quarreling frequently’ was primarily attributed to living in poverty and not being able to provide financial support to families. Another perceived cause of quarreling was a lack of understanding or frustration between generations. One of the effects of these arguments is that older IDPs felt like they were ignored, isolated, and not needed. Key informants said that older IDPs dealt with quarrels by separating themselves from their families temporarily and being on their own or by having others calm them down. Feeling like a ‘burden to family’ was linked with older IDPs having

health problems, being disabled, or being unable to help or provide financial support to their families. This feeling was described as being associated with poor treatment from family members, quarreling and arguments, depression, anxiety, and feeling helpless. Coping mechanisms included encouraging each other, socializing and talking, working, and being listened to by others.

Functioning

Questions three through five in the free list interview were intended to elicit information about functioning in the study population. Of interest was both what older IDPs expected healthy functioning to look like and how they described their own levels of functioning. These perceptions were elicited by inquiring about the tasks and activities that older IDPs engaged in to take care of themselves, their families, and their communities.

The first functioning question had to do with self-care. Most of the free-list responses were related to performing household chores and managing health needs, primarily through medications. In Tbilisi, respondents gave equal attention to the tasks of cooking or preparing food for themselves and their families and of routinely taking medications. Almost a third of respondents also stated that work or income-generating activities were routine tasks in which they engaged. A number of different work occupations were listed, including: housekeepers/ maids, baby-sitters, street cleaners, yard-keepers, doctors, shop-keepers, street-sellers and traders. In Samegrelo the most frequent answer, given by roughly half of respondents, was not a particular task but rather the observation that older adults ‘cannot do anything’ and cannot care for

themselves, mostly because of a lack of regular income. Respondents in Samegrelo also frequently mentioned the tasks of preparing food, washing up and tidying up, and taking care of their health. In Shida Kartli, the most common routine task that respondents listed was taking medications; cooking/ preparing food, washing/ bathing and getting dressed were also mentioned. In Shida Kartli, as in Samegrelo, a number of respondents noted that older adults simply cannot do anything anymore.

A variety of other routine tasks were listed by respondents at a lower frequency, and these responses were given by IDPs across regions. These self-care activities included showing care and affection to spouses, taking care of one's physical appearance, and socializing with neighbors and spouses. In both Samegrelo and Shida Kartli, several respondents listed farming activities, such as looking after livestock or tending plots. In Tbilisi, a few respondents listed religious activities, including going to church, reading religious texts, and fasting. A few other respondents described taking care of their health independent of the formal health care system, including boiling and consuming herbs, doing physical exercises, doing independent research on health problems, and listening to advice on the television.

The second functioning question had to do with how older IDPs cared for their families. The most common responses were related to looking after children and contributing support through financial means. IDPs in all regions also commented that they, or other older people like them, cannot do anything anymore. In Tbilisi, most respondents listed child care as the primary activity they engaged in to support their families. Child care included activities such as accompanying children to school, sports games, and swimming lessons, cooking for and feeding children, and spending time

with and looking after children. Respondents often referred to children in a general sense, suggesting that they took care of whichever children were in their household. At other times, respondents specified that they were referring to their grandchildren. Respondents in Tbilisi also said that they supported their family through financial means, usually with their pensions. In Shida Kartli, most respondents explained that they supported their families primarily through sharing their pensions or other forms of financial support, such as working small jobs. Many respondents also said that they cooked for their families. In Samegrelo, the most frequently mentioned mode of support was again financial support, either through sharing their pension or through trading. Respondents also said that they helped by doing repairs at home and tidying up the home.

Respondents were also asked to describe how they engaged in their communities. Across all regions, the most salient response was that older adults help community members, in good times and bad times, for better or for worse. This included solving communal problems, such as collecting money for new water pipes or for electricity in the collective centers. Supporting each other also meant helping families pay for funerals and weddings, as well as cooking, preparing rooms, and cleaning up after funerals and weddings. In Tbilisi and Shida Kartli, respondents also frequently mentioned talking to each other as a form of communal support. Respondents described older women who gathered in the hallways of collective centers to talk to each other, going outside themselves to socialize in the yard when the weather was nice, visiting with neighbors, and sharing problems at the bus stop. One respondent described 'Bukha's Bar,' a small, curtained off area on one of the floors in the collective center,

where neighbors would gather in the evenings to talk. As one 61 year old widow, displaced from South Ossetia and living in Gori, said: ‘We talk, because there is nothing else to do.’

Discussion

This analysis has demonstrated that there are common salient problems for older adult IDPs across Georgia, including among both old and new caseloads and those living in different settlement types. In particular, analyses of free list interview responses indicate that older IDPs considered health and economic problems to be the most impactful on their lives. Experiences of ill-health and financial hardship intersected in limited access to health care, including prohibitively high costs of medications and a lack of insurance coverage for specialist care and surgeries. In addition, free list respondents and key informants mentioned physical access challenges, including transportation to health facilities, limited mobility, and experiences of physical and social isolation. These experiences were described by IDPs in both rural and urban settings. However, it is often assumed that the urban displaced have greater access to health and social services and other social supports (Skopec, Valeeva, & Baca, 2010). Addressing basic needs, including health care, in urban displacement contexts is uniquely challenging for adults of all ages (Fosu, 1989). Poor economic and living conditions, as well as the particular experiential effects of living in displacement, also affected IDPs’ overall well-being. These IDPs had been living in a prolonged state of both physical and social immobility, without clear solutions to displacement, and for many, a sense of purpose in their communities and lives. This has contributed to a

collective psychological insecurity among IDPs, which has manifested as despondency and feelings of depression, stress and nervousness, as well as feelings of isolation, abandonment, and stagnancy.

Economic problems were of significant concern for older IDPs. These included inadequate pensions and money shortages in paying for medical care, housing repairs, and support for children and grandchildren. Unemployment was another problem, not only because it contributed to money shortages, but also because it prevented IDPs from being active, utilizing their skills and fulfilling their perceived roles. These roles were elaborated upon in IDPs' responses to questions about functioning. For example, IDP respondents described providing financial support to their children and grandchildren as an important aspect of fulfilling their responsibility to take care of their families. However, IDPs were able to look after young children, perform household chores, and participate in community gatherings and celebrations. Patel and Prince (2001) found that older adults in Goa, India described taking part in household work, economic activities, care-giving, and recreational activities. With the exception of the latter, these are similar to the types of activities described by Georgian IDPs in this study. Patel and Prince also found that systems of family care and support for older adults were not always available, largely due to economic factors. The weakening of family and social care structures for older adults is likely to negatively impact the mental health of older populations (Levkoff et al., 1995).

Key informants described a number of coping mechanisms older IDPs engaged in to deal with psychological problems, as well as strategies that families and communities used to provide assistance to older relatives. These included conversing and sharing

problems with friends and family, giving and receiving advice, encouraging self-care, as well as providing social support. Another important coping mechanism was working on plots and carrying out chores within the household. Key informants linked the ability to be active, contribute to family and the community, and fulfill perceived roles with higher levels of functioning and psychological well-being. Key informants in Patel and Prince's (2001) study also listed social support, affection, and caring from family as key remedies for depression among older adults. Informal care networks are essential in the daily management of mental health and psychosocial problems, particularly when formal services are limited (Weine et al., 2008).

The experience of having lived through conflict and displacement had lasting effects on older IDPs' perceived well-being. IDPs described past traumas such as losses of family, property, and homeland, difficulties in adapting to new environments, grieving the past and worrying about the future, a sense of inactivity, apathy, and hopelessness. Although these problems emerged within the contexts of migration and displacement, they were consistently described across respondent samples as permeating older IDPs' daily lives and affecting their overall well-being and functioning. The grief associated with losing property, physical homes, and homeland, as well as the difficulties in adapting to life in displacement, were described as being particularly impactful for older IDPs. It may be more challenging for the older displaced to cope with these losses and changes given the years spent in regions of origin, as well as the individual and collective identities that are linked to these regions. As Cutchin (2001) writes: '[Homes] are containers of memories and a locus of the elder's identity. A home also provides familiarity, security, and control needed by elders' (pg. 31). These

displacement related problems were described as contributing to a range of inter-related psychological problems, including: 1) depression, unhappiness, grief and loss; 2) isolation, hopelessness, and helplessness; 3) nervousness, anxiety, and stress; 4) irritation, quarreling, and conflict; 4) feeling like a burden to the family; and 5) feeling abandoned or neglected by the government and alienated from the wider community . It is possible that individual level experiences of isolation, hopelessness and helplessness are linked with community level experiences of being abandoned by the government and wider community. The consistent expression of displacement related problems across respondent samples can therefore, perhaps, be understood not just as an indicator of a link between displacement and distress, but as local idioms of distress themselves. The experience of being forgotten about, abandoned, and ignored is evocative not just of the experience of being displaced, particularly long-term displaced, but also, significantly, with the experience of being older and displaced. Given the general lack of attention and care for older populations of displaced persons within the humanitarian and services sectors (Burton & Breen, 2002), it is not surprising that IDP respondents felt forgotten about by their communities and government.

Programmatic Recommendations

Key informants consistently reported that there were not enough programs specifically directed towards helping older adult IDPs. Programs for older IDPs should seek to improve functioning by addressing individuals' roles in their communities and providing opportunities for individuals to actively utilize and share their skills. It is important to draw upon the experience, traditional skills and capacities of older persons

in humanitarian contexts. Programs should engage with older persons to both support the elderly and to benefit from their knowledge and skills (HelpAge International, 2000). Interventions that integrate educational and social activity components are useful for preventing social and emotional isolation among older adults (Cattan et al., 2005). Interventions that help older adults build strong social networks, strengthen existing and adaptive care structures, and provide space for social interaction would be useful. Innovative mental health and psychosocial programs for displaced persons should be integrated into existing community care structures and should emphasize capacity building (Rasco & Miller, 2004). Delivering services in the community and accessing the potential of lay providers and informal supports is a key approach in the Inter-Agency Standing Committee's 2007 Guidelines on Mental Health and Psychosocial Services in Emergency Settings and the World Health Organization's Optimal Mix of Services for Mental Health (Inter-Agency Standing Committee, 2007; World Health Organization, 2003). Future work should target not only individual and household experiences of isolation, but should also work on impacting community level experiences of abandonment. This might involve greater communication and information sharing between government representatives, service providers, and communities, and greater resources provided to health promotion and outreach activities and mobile clinics.

Strengths and Limitations

This study relied on the method of free listing for the assessment of significant problem domains in the study population. Free listing was developed as a method for mapping

out cognitive domains by eliciting included terms that semantically belong to those domains. Respondents in this study were initially asked to name key problems. However, not all problems are cognitively available, clearly identifiable, and easy to talk about. Respondents may have had a hard time calling to mind some problems or might not have chosen to talk about sensitive topics. Since mental health issues were of significance in this study, and are not frequently mentioned in comparison with other problems like economic problems and living conditions, the decision was made ahead of time to incorporate another data collection method to further investigate these topics. Another possible limitation is that interviewers took hand-written notes of interview material and did not audio record interviews. It is possible that some material was lost in this process. On the other hand, informants may have chosen to share different, and possibly less sensitive, information in the presence of a recorder. The choice not to audio record was made for this reason and also because hand-written notes allowed for efficient processing and analyzing of data in the field.

Although these findings are specific to the older adult IDP population in Georgia, they are highly relevant for Georgian IDPs of other ages. Some problems specific to older adults have relevance for other older adult populations in Georgia, particularly those who are socially or economically disadvantaged in other ways. It is likely that many issues, for example of isolation, social disconnectedness, inactivity, changing roles in the community, and feelings of abandonment, are of significance to other IDP populations. This study, and the larger investigation that it was part of, was the first of its kind in Georgia to systematically study older adult IDPs' health needs using a range of methods. This qualitative inquiry combined systematic and in-depth interview

methods of data collection. This use of complementary methods allowed for the elicitation of a range of topics and material. This method has been successfully used in numerous other sites (Bass et al., 2008; Bolton & Tang, 2004; Murray et al., 2012).

Conclusion

This paper has presented the results from a qualitative study that was part of a larger mixed methods investigation into the physical and mental health status of older adult IDPs in Georgia. Data collection took place in 2010 and 2011 and initial analyses took place in 2011, while more in-depth analyses were done in early 2012. This paper was drafted during the second half of 2012 and early 2013. This study has highlighted the needs and health status of older adult displaced persons, a population that needs greater attention from the humanitarian community. In particular, states and international actors need to promote programming that is tailored to the needs of older adults. The results from this study have suggested that strengthening social support systems, informal networks of care, health care access, as well as providing opportunities for meaningful engagement in the community may all be important for improving the well-being and functioning of older displaced persons.

Tables

Table 3.1. Characteristics of IDP Participants in Free List Interviews, By Study Region

Study Site	Tbilisi	Shida Kartli	Samegrelo
Location of site in Georgia	Central/ Eastern Georgia	Central Georgia	Northwestern Georgia
Origin of the population pre-displacement	Abkhazia	Ossetia	Abkhazia
Number of people interviewed	F=15 M=10 Age range=60-82	F=14 M=11 Age range=61-84	F=15 M=10 Age range=60-94
Time period of displacement	1990s	1990s 2008	1990s
Type of housing	Private accommodation Collective centers	Private accommodation Collective centers New settlements Buffer zone, on border of South Ossetia and Georgia	Private accommodation Collective centers
Most frequently mentioned displacement related problems (from most to least frequent)	-Indifference of others towards IDPs -Desire to return to Abkhazia -Not owning living space -Lack of living space -Fear of eviction -Grieving what was lost -Not having any privileges -Being unable to visit family graves	-Indifference of others towards IDPs -Desire to return to Ossetia -Having nothing -Grieving what was lost -Not having gardens -Everything is burnt -Lack of living space	-Desire to return to Abkhazia -Indifference of others towards IDPs -Not owning living space -Grieving what was lost/ Having nothing -Not having plots -No assistance -Feeling like a prisoner/ Lack of living space
Most frequently mentioned mental health problems (from most to least frequent)	-Worries about children -Feeling depressed -Feeling hopeless	-Feeling nervous -Feeling depressed	-Hardship -Fearing the future -Having nobody/ Loneliness -Feeling tormented -Nothing makes me happy

Table 3.2. Characteristics of Participants in Key Informant Interviews and Selected Core Themes for Key Informant Interviews, By Study Region

Study Site	Tbilisi	Shida Kartli	Samegrelo
Number of people interviewed	F=12 M=3 Age range=26-63	F=7 M=8 Age range=23-56	F=11 M=4 Age range=27-80
Selected key informant interview themes: For all sites	-Nervousness -Nothing makes me happy		
Selected key informant interview themes: Site specific	-Feeling abandoned -Feeling isolated	-Impassivity/ Having nothing to do -Lack of concern	-Quarrel frequently -Burden to family/ Cannot help family

Table 3.3. Most Frequently Mentioned Problem Categories in Free List Interviews, By Study Region

<i>Tbilisi</i>	#	<i>Shida Kartli</i>	#	<i>Samegrelo</i>	#
Health problems	27	Health problems	42	Health problems	27
No money for medicine	16	No health insurance	12	Poor living conditions	11
No health insurance	15	No money for medicine	11	Lack of money	9
Indifference of others towards IDPs	13	Small pension	11	Unemployment	9
Small pension	12	Unemployment	8	No money for medicine	8
Lack of money	10	Lack of money	8	Small pension	8
Unemployment	9	Poor living conditions	7	Desire to return to Abkhazia	6
High taxes	6	Indifference of others towards IDPs	5	Affording firewood or electricity for heat	6
Desire to return to Abkhazia	5	Desire to return to Ossetia	5	Indifference of others towards IDPs	5
Not owning living space	5	Family members' illnesses	5	Not enough food	5
Poor living conditions	4	Ineffective medical treatment	4	Expensive medical treatment	5
Worries about children	4	Having nothing	4	Not owning living space	5

Chapter 4. ‘Getting Used to It’: A Grounded Theory of Living with Displacement and Becoming Integrated among the Long-term Internally Displaced in Georgia

Abstract

Dominant models of recovery in mental illness and ‘recovery’ in protracted displacement emphasize the importance of social cohesion, community connectedness, social roles, personal purpose, and evolving identities. In Georgia, the government has prioritized local integration as the primary strategy for addressing its internally displaced population. Georgian IDPs must negotiate the transition to integration within the context of changing state structures and limited access to health and social services. This study examined the confluence of identity, integration, psychosocial problems, and social support seeking among long-term IDPs. The potential of the household in displacement and the IDP shelter space for recovery trajectories was explored. In 2012, in-depth semi-structured interviews were conducted with 10 adult long-term IDPs living in a collective center in Zugdidi and a compact settlement in Tbilisi. A Grounded Theory methodology was employed to develop a theory of ‘Getting Used to It.’ Rosi Braidotti’s nomadic theory was used as a critical frame to conceptualize the process of becoming integrated. Data analysis involved coding, memo-writing, and the development of theoretical constructs. Participants’ narratives suggest that becoming integrated is transformative and affects notions of self, identity, place and home. Integration is a complex and relational process that IDPs co-create by ‘Getting Used to It.’ Recovery in chronic displacement involves reclaiming identity and one’s place in the community. This has implications for how formal services are accessed. Sense of belonging and integration affects how individuals seek care. Services directed to IDPs must consider the role social connectedness and integration plays. Mental health and psychosocial programs in displacement contexts should pay attention to rebuilding connections, social roles, and a sense of hope for the future.

O azure sky, O emerald earth,
I hasten to you, native strand;
I come, afflicted; ease my heart
That inly bleeds, O mother-land.

I stand entranced upon the Mount
And feel once more revived and whole.
My bosom swells, and then in song
I pour the worship of my soul.

Exiled from home I wandered on
And wept to live from you apart;
I yearned for you, to you made haste
With ardent soul and eager heart.

--Excerpt from *Dawn*, Akaki Tsereteli (1840-1915)

I am conscious of myself and become myself only while revealing myself for another, through another, and with the help of another. The most important acts constituting self-consciousness are determined by a relationship toward another consciousness. . . *To be* means *to communicate* . . . To be means to be for another, and through the other for oneself. A person has no internal sovereign territory, he is wholly and always on the boundary: looking inside himself, he looks *into the eyes of another* or *with the eyes of another* . . . I cannot manage without another, I cannot become myself without another.

--From *Problems of Dostoevsky's Poetics (Theory and History of Literature)*, 1984, Mikhail Bakhtin

Background

‘Recovery’ has been variously approached in mental health literature, but is often understood to be a dynamic, ongoing, and non-linear process of change and transformation (Davidson & Roe, 2007; Jacobsen & Greenley, 2001; Substance Abuse and Mental Health Services Administration, 2011; Tondora, Heerema, Delphin, Andres-Hyman, O’Connell & Davidson, 2008). Recovery can be understood in terms of thresholds and dimensions of change. Given the chronic nature of many mental illnesses

and the difficulty of clearly measuring endpoints in the course of an illness, distinctions have also been drawn between full recovery ‘from’ mental illness and recovery ‘in’ or management of mental illness (Davidson & Roe). This study examines the intersections of psychological well-being and experiences of home and community among a group of individuals living in protracted urban displacement in Georgia. The study considers how these internally displaced persons (IDPs) construct their identities and relationships with each other in the face of displacement and its daily challenges and consequent psychological struggles. In the context of chronic displacement, recovery might be understood as the process of becoming integrated, or transitioning out of active displacement. Recovery in both mental illness and displacement are inherently social processes that involve sharing inner worlds and traumas, healing fractured selves and identities, accessing support from informal networks and formal services, and building social bonds and community. This study considers IDPs’ experiences of social integration into their host communities, as well as their decisions about seeking social support and care within their households and social networks. How do IDPs navigate and actively co-construct pathways to care and social support structures? How do they traverse geographic places and construct social spaces to access support and healing? Further, how do IDPs understand psychological problems, relate them to their displacement experiences, and integrate them into their sense of self? Becoming healthy and becoming integrated are intersecting transformative processes that rely on hope, aspirations for the future, and community supports.

Applying models of mental illness recovery to displacement

The United States Substance Abuse and Mental Health Services Administration (SAMHSA) has defined recovery from mental disorders and substance use disorders as: “A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential” (Substance Abuse and Mental Health Services Administration, 2011). SAMHSA has presented a model of recovery that includes four dimensions: 1) Health, or overcoming and managing disease; 2) Home, or having a stable and safe place to live; 3) Purpose, or having meaningful activities and social roles; and 4) Community, or relationships and social networks that provide support and hope. Tondora et al.’s (2008) definition of recovery focuses on identity and belonging: “the ways in which a person manages a mental health and/or substance use condition in the process of restoring or developing a meaningful sense of belonging and positive sense of identity apart from this condition and while rebuilding a life despite or within the limitations imposed by this condition” (p. 7). Regaining one’s sense of self or identity does not occur in isolation, however, and recovery is linked with social inclusion within communities rather than segregated services (Shepherd, Boardman & Slade, 2008). Jacobson and Greenley (2001) have developed a conceptual model of recovery in mental illness that comprises two dimensions, each with sub-components, which work in tandem. The first dimension is concerned with internal conditions including hope, healing, empowerment, and connection. Hope is a transcendent process that entails focusing on strengths and looking to the future as opposed to remaining in the past. Healing has to do with recovering the self by “defining a self apart from illness” and “reconceptualizing illness as only a part of the self, not as a definition of the whole”

(Jacobsen & Greenley, p. 483). Empowerment refers to gaining control and moving beyond feelings of helplessness and passivity. Finally, connection refers to recovery being a social process that involves “rejoining the social world” (Jacobsen & Greenley, p. 483), finding social roles, helping others with similar problems, and sharing personal stories. Through these processes, individuals come to terms with their own experiences. The second dimension, external conditions, includes a human rights agenda for organizations and communities, a positive culture of healing amongst professionals that focuses on collaboration, hope, and trust, and finally, recovery-oriented services.

There are numerous parallels between the process of recovery in chronic mental illness and recovery in chronic or protracted displacement. Achieving health and finding homes, communities, and a sense of purpose are crucial steps for individuals transitioning out of displacement. The process of integration for displaced persons also involves reentry in communities, social inclusion, social roles, and redefining the self apart from labels or traumas. As with Jacobsen and Greenley’s (2001) model, recovery in displacement involves both internal processes and social connections and requires supportive organizational and community structures and cultures. Social and place integration is dynamic, relational, and multi-dimensional. This analysis uses the term ‘integration’ to refer both to the broader experience of social cohesion, connectedness and belonging (Durkheim, 1951; Kawachi & Berkman, 2001) and the normative approach of local integration, as outlined in the Guiding Principles on Internal Displacement (United Nations Office for the Coordination of Humanitarian Affairs, 2001). In so doing, it seeks to contribute to the conceptual development of integration

within the humanitarian and development sectors, as well as to the development of mental health and psychosocial support programs for Georgian IDPs.

Local integration as a solution to internal displacement

By the end of 2012, the total number of internally displaced persons, or IDPs, worldwide, as a result of armed conflict, generalized violence, and human rights violations has been estimated to be 28.8 million. This is twice as many IDPs as refugees (Internal Displacement Monitoring Centre, 2013b). However, legal instruments and standards for addressing internal displacement crises are more limited than the frameworks that exist for refugee populations. Of key concern is developing strategies for so-called ‘durable solutions’ for internal displacement, an approach that parallels the normative approach used in refugee contexts. In 2010, the Inter-Agency Standing Committee and the Brookings Institution developed a framework on durable solutions for internal displacement, which lists three basic strategies. A ‘durable solution’ is defined as having been achieved when “internally displaced persons no longer have any specific assistance and protection needs that are linked to their displacement and can enjoy their human rights without discrimination on account of their displacement” (p. iii). The three strategies that are outlined are: 1) Sustainable reintegration at place of origin, or return; 2) Sustainable integration in areas of refuge, or local integration; and 3) Sustainable integration in another part of the country, or resettlement in country (Brookings Institution & Inter-Agency Standing Committee, 2010). However, durable solutions must be understood as dynamic and evolving processes, rather than processes with fixed end-points. This requires engaging with displacement situations beyond the

immediate crisis periods, as well as conceptualizing durable solutions as both humanitarian and development projects (Internal Displacement Monitoring Centre).

Established norms on durable solutions emphasize safe and voluntary return or relocation, as well as a range of choices about living conditions. However, without a genuine set of choices, government policies or individual strategies cannot be considered truly durable, nor can displacement be considered over. Local integration in place of refuge often becomes a de facto solution in situations of protracted displacement when government policies for IDP populations are absent or incomplete or when return or facilitated resettlement are not options (Ferris, 2011). Indeed, the United Nations Special Rapporteur on the Human Rights of Internally Displaced Persons, Chaloka Beyani, has stated that: “While the choice of durable solutions must be an informed and voluntary one by IDPs, I believe that more emphasis needs to be placed on local integration as a settlement option through which IDPs may achieve a durable solution” (Ferris, p. 3). Local integration may be more acceptable as a strategy when presented as allowing IDPs “to enjoy their rights and live in situations of dignity while awaiting the possibility of return” (Ferris, p. 17) instead of as a permanent solution. In some contexts, IDPs may prefer local integration solutions because of continued fear of return, even if a safe return is possible, and local integration may be more feasible when language and culture between IDPs’ places of origin and host communities is shared (Crisp, 2004). Indeed, in the absence of a true set of choices, local integration may not be a durable solution, but rather an option for re-establishing lives, connections, possibilities, and identities. Local integration is a complex and gradual process which comprises distinct but related legal, economic, social, and cultural dimensions and

imposes considerable demands on both the individual and the receiving society (Crisp; Brookings Institution & Inter-Agency Standing Committee, 2010). In contexts of protracted displacement, local integration requires both IDPs and hosts to accept and build relationships with each other (Brun, 2008 as cited in Badurdeen, 2010).

When can displacement be pronounced ‘over’? When can IDPs consider themselves to be once again integrated into the landscapes and lifestyles of their countries? Conceptualizing and measuring when internal displacement ends is not straightforward, and there are differing opinions on how to assess this point. However, as Mooney (2003, as cited in Cernea, 2003) has noted, IDPs have a right to know and receive information about the trajectory of displacement from legal and political viewpoints, as well as when displacement ends, and what recovery will entail (Mooney). Martin and Mooney (2007) outline three sets of criteria for assessing the end of displacement. The first is “Cause-based criteria,” which would require an examination of the causes of internal displacement and an evaluation of changed circumstances as a marker of the end of displacement. The second, “Solutions-based criteria,” would require that an IDP has voluntarily and safely returned or resettled and is successfully reintegrated in the community of residence. The third set of criteria is “Needs-based criteria,” which requires a consideration of the continued presence of risks and vulnerabilities that are specifically tied to IDP status. Cernea raises the important point that debates over when displacement ends have important implications for the definition of indicators and measurement indices. Challenges in measurement also hold true for assessing when and how local integration is achieved, particularly given that it is a multi-dimensional construct. This study seeks to advance this process by examining

the social and psychological dimensions of local integration, including access to health services, informal support seeking behaviors, perceptions of belonging, and inter-connectedness. In so doing, this analysis will contribute to the theoretical development of local integration in contexts of internal displacement from public health and mental health services perspectives. This is important as examinations of local integration from the perspectives of mental health, psychological and social support informal care-seeking, and health services access have been limited.

Ager and Strang (2008) have developed a conceptual model of integration in the context of forced migration, which serves as a useful contextualizing framework for this study. Their model includes the following core domains: Markers and Means (employment, housing, education, and health); Social Connection (social bridges, social bonds, and social links); Facilitators (language and cultural knowledge; safety and stability); and Foundation (rights and citizenship). Ager and Strang consider good health and health access to be important aspects of integration and engagement in society and include health in their operational definition of integration. However, they note the challenge of measuring ‘successful integration’ in areas such as health, education, and housing, given the disparities in status and access that all residents face. What, then, should be the standard for IDPs as a disadvantaged group? They also emphasize the importance of social connectedness in achieving integration. In particular, integration is considered to be a “process of mutual accommodation” (Ager & Strang, p. 177) and social connection between displaced persons and other members of their communities. Ager and Strang carried out a qualitative examination of the integration experiences of refugees in the United Kingdom. They identified several

factors contributing to social connectedness, including the absence of conflict and interaction among groups. Participants identified ‘belonging’ as the “ultimate mark of living in an integrated community” (Ager & Strang, p. 178). Belonging had to do with “links with family, committed friendships and a sense of respect and shared values” (Ager & Strang, p. 178), as well as a balance between one’s personal identity and wider sense of belonging.

Integration in the Georgian context

In the case of Georgia, safe and peaceful return to Abkhazia or South Ossetia is not currently possible for IDPs, given ongoing disputes over these territories. Indeed, Ferris, Mooney and Stark (2011) refer to the conflict in Georgia as “frozen” (p. 131), as active conflict has stopped but resolution of conflict in the immediate future is unlikely. Although local integration was not initially preferred by the GoG, as it suggested a forfeit of the possibility of return and reclaiming Abkhazia, it is currently the primary state strategy (Ferris, Mooney, & Stark). This is outlined in the GoG’s 2007 State Strategy for Internally Displaced Persons. The State Strategy currently prioritizes durable housing solutions as its primary approach to achieving integration, including renovation and privatization of government shelters for IDPs and relocation of IDPs to new purpose-built structures. Section 3.2 of Georgia’s State Strategy outlines several elements of socio-economic integration that must be fulfilled, including “Infrastructure rehabilitation; access to health and social services as well as psychological support and counseling; targeted social assistance; access to education, livelihoods, economic opportunities and employment with the equal participation of man [sic] and women”

(Government of Georgia, 2012). Mitchneck et al. (2009) found that Georgian IDPs view community integration as more complex than geographical proximity to the local population and as involving “socio-spatial relations.” Although the State Strategy emphasizes housing solutions, Mitchneck et al. found that resettling IDPs into new settlements or homes was not enough to create a sense of integration. As the authors state: “If dwelling type or spatial collocation does not largely shape social networks, then the issue becomes the specific mechanisms or spaces that can change patterns of social interaction” (p. 1031). Mitchneck et al. conclude that supporting livelihood opportunities is the primary means by which to promote local integration.

Kurshitashvili (2012) has written about the GoG’s recent eviction policies and actions among IDPs and notes that current resettlement policy has focused almost exclusively on providing housing, while neglecting to promote sustainable livelihoods. A 2012 report from the United Nations High Commissioner for Refugees (UNHCR) in Georgia examined the status of IDPs displaced in 2008 who have returned (i.e. returnees) to their region of origin, Shida Kartli. The assessment found that most residents in returnee villages lacked health insurance, as well as information about their coverage. The exception was those individuals who were formally employed or recipients of support from the GoG’s social assistance program. Teachers talked about trauma among children, and returnees also mentioned that most of the population were recovering from war related trauma and would benefit from psychological support. The extent to which IDPs are able to fully participate in and engage with the local community, for example through integrated health and social services, as well as integrated housing, has implications for their experiences of community, belonging, and

connectedness. A greater sense of connectedness should also increase utilization of health and social services, civic participation, and social exchanges with non-IDPs.

What new identity will IDPs have that acknowledges their particular displacement experiences, as well as their Georgian citizenship? To what space and identity are IDPs aspiring towards and becoming? Local integration has implications not just for the evolution of individuals' trajectories and identities, but for the development of an inclusive national identity. Protracted IDPs in Georgia have struggled with their own fractured trajectories and have also been caught in a particular historical moment of national transition. They have not yet been able to fully engage with the national community and identity that has evolved since Georgia's independence. Pelkmans (2006) has examined the historical and cultural divisions and borderland identities of Adjara, a region in southwestern Georgian that extends into Turkey. He challenges the assumption that the nationalist trajectories of post-Soviet republics have involved a clean return to carefully preserved pre-Soviet identities "that were held in "cold storage" (p. 10). He contends that national identities have not simply emerged in response to the " "ideological vacuum" left by the collapse of the Soviet Union" (p. 10). Rather, the legacy of Soviet rule has persisted in its influence on national identities, at times in unintended and unforeseen ways.

One of these unintended, perhaps sub-conscious or even subversive, ways has been through the shaping of sub-domains of identity across borders and disputed territories, even by national actors in whose interest it is to maintain a unified identity. As Nodia (2005) writes: "Becoming one nation has proven to be the greatest challenge Georgians have faced since gaining independence" (p. 44). The adoption of an

international humanitarian lexicon and perpetuation of sub-identities such as ‘local Georgians’ vs. ‘Georgian IDPs’ or ‘old IDPs’ vs. ‘new IDPs’ complicates the development of an inclusive Georgian identity. On the one hand, the incorporation of the international normative Guiding Principles on Internal Displacement into national legislation and provision of IDP status affords displaced persons from Abkhazia and South Ossetia an essential set of legal and social protections as well as recognition by the international aid community. In addition, IDP status provides displaced persons with a unique and shared identity, one that acknowledges the particular struggles and experiences individuals have endured through displacement. The protections, facilitated access to designated social and legal services, and community that such labels provide have been recognized as essential (Zetter, 1991). Unlike some countries containing significant IDP populations, the GoG recognizes its IDPs, cooperates with international authorities, and has been making concerted efforts to find durable solutions, primarily through securing housing. Although these strategies continue to be implemented, and have had varying degrees of success thus far, they are important steps. On the other hand, continuing to enforce differences defined by borders and movements across borders continues a historical legacy of drawing boundaries and of shaping and re-shaping what it means to belong to Georgia. This undermines the development of an integrated state. As Helly and Gogia (2005) write:

Georgia’s unresolved internal conflicts in Abkhazia and South Ossetia have seriously hampered the country’s political and economic development and, in the process, its stability. . . . These conflicts have generated tension between Georgia and Russia, displaced hundreds of thousands of people, inflicted trauma on whole populations, and pitted community against community. It is impossible to conceive of Georgian security without a settlement of these conflicts. (p. 283-284)

This is a creation and segregation of sub-groups—those who truly belong as Georgian citizens and those who have not yet achieved this status and who, instead, remain frozen in a post-Soviet transition space. Georgia’s recent evictions of long-term IDPs in 2010-12 (Amnesty International, 2011) which resulted in both national and international outcry and have since ceased, continued to displace and fracture a collective Georgian identity. The enduring ‘in transition’ status Georgia has held since the breakup of the Soviet Union might be considered a grander and more complex version of the protracted transition space in which IDPs continue to live. It is important to consider what kind of state Georgia has been becoming and how its evolving national identity will accommodate individuals still catching up in their own identity transformation. Both transformations are ongoing and impact the ‘becoming’ of the other.

Becoming integrated

This study draws on Rosi Braidotti’s conceptualization of nomadic theory, as presented in her text *Nomadic Theory: The Portable Rosi Braidotti* (2011), as a critical frame. Braidotti’s nomadic theory was identified and applied to the analyses of data after initial inductive coding and memo-writing of data was carried out. This theoretical orientation was identified as relevant to the data and emergent theoretical constructs and was thus used to contextualize the findings. The principles of nomadic theory have been addressed by a number of writers but were largely developed by French philosopher Gilles Deleuze and French psychoanalyst Pierre-Félix Guattari (1984), who termed it nomadology. For Deleuze and Guattari, the nomad represents what is unstructured and unbounded, versus what is hierarchical and predetermined. The nomadic subject is not

constrained by change, movement, and what is in flux or uncertain but rather is aware of the potential of unfixed identities and shifting social space and is thus transformed; the nomad is constantly becoming (Koppensteiner, 2009). Further, Deleuze's consideration of "becoming nomad," according to Braidotti, has to do with transcending labels, set identities, and deconstructing definitions of membership (Braidotti). The notion of the nomadic subject may be understood as "a (non structured) form of one's own identity" (Saleri, 2010). For Braidotti, the potential of the nomadic subject is in this lack of structure, in a multi-faceted and perhaps fractured sense of self:

[W]e have to think about the multiple forms of belonging of subjects and map out different configurations of nomadism, different ways in which a subject can have multiple belongings, multiple ways in which ethnicity, nationality and citizenship can actually be combined, even within the same nation. . . nomadic is a verb, a process by which we map out multiple transformations and multiple ways of belonging, each depending on where our particular location is and how we grow. So we have to map out the alternative cartographies of the non-unitary subjects that we are, so that we can get rid of any idea that there are subjects that are completely unitary, belonging entirely to one location. . . Nomadism is a qualitative shift of consciousness, that makes you inhabit the positions of power so as to change it. (Saleri, 2010)

Nomadic theory concepts were used to understand and situate the theoretical constructs that developed from data analysis procedures. Concepts were used to contextualize the experiences of these IDPs who are a marginalized community irrevocably affected by pain, vulnerability, and traumatic memories but nevertheless seeking to claim a particular place and identity. 'Becoming an IDP' and 'Becoming Integrated' are evolving, non-linear, and fractured processes. Particularly in contexts of protracted displacement, 'Becoming an IDP' and 'Becoming a non-IDP' are not, in fact, experientially dichotomous categories. Indeed, since 2007 UNHCR has recognized this through its application of the sub-category of "people in IDP-like situations," which

refers to people living inside their country who logistically or otherwise cannot be reported as IDPs but who face vulnerabilities similar to those of IDPs (UNHCR, 2013). Although the label of IDP and accompanying legal status may be applied or removed at distinct and measurable time-points, ‘Becoming Displaced’ and ‘Becoming Integrated’ are transformative and intersecting processes without end. With resources, protections and services, IDPs may be able to simultaneously claim and transcend their displacement experiences and identities. Braidotti’s analysis of becoming nomadic is utilized to reflect the transformative potential of IDPs to claim their ever in-transition state and shifting subjectivities and to become powerful, responsive, and resilient.

Methods

This study addresses the process of ‘Becoming Integrated’ from the perspectives of long-term Georgian IDPs. It considers how perceptions of community connectedness, belonging, and trust impact social support seeking and IDPs’ personal trajectories within displacement. This study emerged from a larger study on mental health care-seeking behaviors and trajectories among long-term urban IDPs in Georgia. In 2010-11, the author carried out site visits and ethnographic observations of mental health and psychosocial service sites and collective centers, as well as in-depth, semi-structured interviews with 16 key informants and 39 IDPs. Key informants were based in Tbilisi, the capital city, and Zugdidi, an urban center in northwestern Georgia, while IDPs were all living in and around Zugdidi, mostly in collective centers. A total of 78 IDP interviews, or two interviews per IDP, were carried out, including interviews with 9 IDPs who had accessed state in-patient psychiatric services. An analysis of three narratives of

care-seeking from this sub-sample of 9 IDPs is presented in Chapter 5. Analyses of these data suggested a strong parallelism between care-seeking decision-making and experiences of social embeddedness. To investigate this parallelism and emergent theoretical constructs further, theoretical sampling was carried out with additional key informants and IDPs in 2012. In this last round of data collection, interviews were conducted with four key informants, all based in Tbilisi, and 10 IDPs living in a collective center in Zugdidi and a compact settlement in Tbilisi.¹ This study examines the narratives of this latter sub-set of 10 IDP interviews. Linkages between these IDPs' experiences of community, social space, support seeking, and the urban built environment are examined. In so doing, this study illustrates how support seeking and personal trajectories are inextricably linked with experiences of local integration.

In-depth interviews with IDPs ranged from 45 to 120 minutes in length and followed a semi-structured interview guide. Interviews with IDPs were mostly conducted in Georgian; some participants spoke a mix of Georgian and Mingrelian, a Kartvelian language related to Georgian that is spoken in northwestern Georgia and Abkhazia. Interviews were conducted by two Georgian research assistants experienced in social science research, qualitative methods, and research with IDP communities. All interviews were digitally recorded, transcribed, and translated by the research assistants and a Georgian translator. The author trained the research assistants and translator in 2010-11 and worked extensively with them. Both the translator and the research

¹ Both the terms 'collective center' and 'compact settlement' refer to state-owned or private residences where groups of IDPs were temporarily accommodated in an organized fashion and have lived for a long period of time (Brookings, 2006; Government of Georgia, 2007). This study primarily uses the more commonly used term, 'collective center.'

assistant who carried out the Zugdidi interviews were themselves displaced from Abkhazia and spoke Mingrelian.

IDP residences were purposively selected. The collective center in Zugdidi was selected because it was an urban center that had not been previously visited in earlier rounds of data collection; it was mid-sized, and living conditions were mid-range, meaning that they were neither extremely destitute nor renovated. Since the study was concerned with social spaces and social support seeking, living environments needed to be conducive to some social interaction and not so poor that residents would only be interested in speaking about physical or environmental conditions. The compact settlement in Tbilisi was selected with the assistance of a local contact who works for NGO X, an organization that addresses various needs of conflict-affected communities in Georgia. This contact was known within the settlement and provided us with an introduction to a resident. An introduction was necessary in Tbilisi because of higher levels of mistrust towards visitors to collective centers due to the run-up to the parliamentary election that was occurring at the time of data collection, as well as to the recent history of forced evictions of long-term IDPs in Tbilisi. In addition, there was greater social distance between IDPs and local residents in Tbilisi. IDP participants were selected using purposive maximum variation and chain sampling approaches in order to select different genders and ages (See Table 4.1 for IDP participant demographics). As mentioned above, this data collection was also part of a theoretical sampling approach within the larger study. Each participant provided informed consent to participate in the study and was compensated for his or her participation with 20 Georgian lari. The research ethics and protocol of this study was reviewed and approved by Institutional

Review Boards at the Johns Hopkins Bloomberg School of Public Health and the Georgian National Center for Disease Control and Public Health.

This study employed a Grounded Theory (Glaser & Strauss 1967; Strauss & Corbin, 1990) methodology using the constructivist version outlined by Charmaz (2006). Data analysis procedures conformed to constructivist Grounded Theory methods and involved a series of iterative and recursive steps, including transcript reviews, open coding, descriptive memo writing, focused and theoretical coding, identification of categories, analytical memo writing, theoretical construct development, sorting of categories and constructs, theory development, and diagramming. These steps were not carried out in a linear fashion but rather involved cyclical feedback loops, with each loop resulting in progressively more conceptual findings. After initial rounds of open coding and memo writing were carried out, the critical framework was integrated in analysis procedures through the use of theoretical codes and while integrating and writing up analytical memos. The analysis process led to the development of a Grounded Theory of “ ‘Getting Used to It’: Living With Displacement and Becoming Integrated.”

Credibility of findings was assessed in several ways. First, key focused codes and theoretical constructs were reviewed in light of the data collected in the earlier round of the study. Preliminary results were presented at several international conferences in the disciplines of forced migration, anthropology, psychiatry, and mental health. In addition, key categories and constructs from the emergent theory were reviewed in light of findings from Study 3, presented in Chapter 5. Study 3 findings fit with these categories, suggesting that the categories were applicable to and relevant for a different sample of Georgian IDPs. The dependability of findings is further strengthened by the

use of trained and experienced research assistants, as well as by reflection sessions with each of the assistants after interviews were conducted.

Study Findings: ‘Becoming Integrated’ as a Transformational Process

Getting Used to It

Over and over again, in their narratives, IDPs used the phrase “got used to it” to describe their lives in displacement, in the collective centers, and in their host cities. These were the words IDPs chose to explain the extent to which they felt integrated and comfortable in their communities. This was how IDPs ultimately understood and came to terms with the limbo and uncertainty in which they lived; it was the process they engaged in to cope with living in, and with, displacement, and it was the way in which they allowed for their memories, sense of home, and identities to evolve. ‘Getting Used to It’ was the core process around which IDPs’ narratives and key thematic constructs revolved. This was not an easy or welcome process but rather occurred over time and with a sense of ambivalence and reluctance. The process was gradual, difficult, and not always engaging or productive. This was an outcome that happened to IDPs as a result of years spent without homes of their own or a clear future; this was not something that was elected. ‘Getting Used to It’ references the passivity many IDPs described experiencing in themselves and others—this is a process that often occurs without active effort on the part of these individuals. The process also references the lack of choice many felt with regard to their living conditions and status, as well as the reluctance of individuals to acknowledge their present lives and move on from their lives in Abkhazia.

‘Getting Used to It’ reflects the length of time spent in displacement as well. ‘Getting Used to It’ as a core process and strategy was thus incremental, often unintentional, and ongoing.

This process of ‘Getting Used to It’ was what participants referred to when explaining what life was like in the collective centers and in their host communities. IDPs felt that that over time they had adapted to and belonged in their host communities because they were physically there, because they had lived there for a long period of time, and because they were used to it. This process thus became the sole indicator of what it meant to be a part of the wider community. Sense of ownership of homes and community thus occurred by default, simply as a result of their presence there over a period of time. Belonging to the collective center or broader community was less of a choice or an experience that had evolved over time in displacement and more of an experiential outcome. For perhaps these reasons, IDPs expressed a sense of apathy over their connections to Zugdidi and Tbilisi and the centers; they stay in the centers not because they want to but because they are used to it. Giorgi², who lives in Tbilisi and was 50 at the time of our interview, was asked whether he wants to continue living in the collective center. He explains that: *[I]f there is no return, then of course. I want that very much. When asked why, he says: If there is no return, now we got used to each other so much, the neighborhood, everything, is that a little? It’s a new stage of life; new stage in life.*

² All names are pseudonyms

Though IDPs have become used to life in the collective center and to a certain extent feel like a part of the wider community, many still experience a sense of separation and do not feel fully integrated. Tamriko, a 44 year old woman, explains that she and others in the settlement do not perceive the settlement as being part of Tbilisi and refer to going into the rest of the city as “going to the city”: *[I]n fact, I don’t live in Tbilisi, so to say. Really, when we go out, we say that we go to the city, just like I said right now; I go to the city. . . Usually people go to the city from villages, from suburbs—when they dress up and go to the city, there’s such a moment; we go to the city; this is a small village. Despite the fact that it belongs to [neighborhood in Tbilisi].* Tamriko thus expresses both a sense of separation from the rest of the city and a sense of connection with other IDP residents. This notion of the settlement being like a small village was expressed by most participants. Tamriko further explains how the settlement is experientially different from the rest of the city: *And here, it’s encircled, and there are concrete blocks built and when you enter, you enter a different world already. When I go out, now I got used to it, I got used to it a little bit, it’s fine.* Not all IDPs experienced this difference, however, and IDPs in Tbilisi expressed a greater sense of difference from the rest of the community than did IDPs in Zugdidi. For example, Eka, who lives in Zugdidi, feels like she is the same as any other Zugdidi resident: *I don’t see a difference between locals and myself. I’m like a regular Zugdidian; I’m like a person from Zugdidi too.*

‘Getting Used to It’ does not imply an acceptance of living conditions; indeed individuals aspired toward something different including the ability to own their homes. However, individuals were still hesitant at the prospect of completely uprooting

themselves again, perhaps remembering their earlier uprooting from their homelands. Tamriko describes this tension: *No matter who you go to, everybody will tell you that they only want to be evicted from this place and they don't want to live with anybody, but once they think about it, it's still like this. We have been living here for so long; children have been born and grown up here, without each other, when they said that they will evict us, the young children were so upset, they are already settled here.*

Several IDPs explained that it was their children's connection to the city that ultimately tied them there, and the fact that their children had grown up in the collective center contributed to their perception that they too, perhaps, belonged to their host cities. Mari explains that if they are able to return to Abkhazia she has joked with her teenage children that she plans to go, even if it is without them:

Now in this very moment of course, because my children already want to be here and of course I belong. But if there is a return, probably nobody will stop me, I tell the children 'If you won't come, I will still go'. I still tell them that. They say that they aren't coming anywhere, but they are old enough, probably I could leave them here [laughing]. And I will take the youngest one with me of course and I don't know. I might not be able to stay there, I don't know what will be the situation there.

This uncertainty about the future and what a potential return might involve contributes to the hesitant acceptance of life in the centers. Eka does not want to return to Abkhazia because she believes her children's education will be better served in Georgia.

IDPs tended to use the explanation that they "got used to" life in the collective center and living with other IDPs when describing perceptions of belonging. 'Getting Used to It' has less to do with an emotional connection to a community and more to do with time spent in and familiarity with a community, as well as with the physical placement of the centers. This suggests a belonging by default, rather than a deeper

sense of connection. 'Getting Used to It' progresses with time, but Mari and others expressed the sense that for them, time had stopped long ago since their lives were interrupted after the war and never fully started again. Still, 'Getting Used to It' also reflects the processes of adaptation, transition, and integration. A couple of participants noted that it would be difficult if they were evicted, had to move somewhere else, and go through the process of adapting to a new environment all over again. 'Getting Used to It' was a declaration of some sense of connection, although not necessarily of choice. Teá, a 19 year old university student, explains that she does not want to have to choose between living in Gali, right across the Georgia-Abkhazia border in Abkhazia, or Zugdidi. She does not know whether she would prefer to return, given her family's connection to Abkhazia and her relatives who are still there, though she never lived there herself, or continue to live in Zugdidi, a city she does not want to give up: *I've been living here for 15 years and I already got used to this environment very much.*

'Getting Used to It' is a process of coping, adaptation, and 'Becoming Integrated.' It leads to a perception of belonging or integration by default, but it is never a completed process, largely due to the social and emotional divisions created by displacement. Braidotti (2011) writes about the psychological displacement that results from losing one's identity and sense of place: "Changes that affect one's sense of identity are especially delicate. Given that identifications constitute an inner scaffolding that supports one's sense of identity, shifting our imaginary identifications is not as simple as casting away a used garment. . .imaginary relocations are complex and as time-consuming as shedding an old skin" (p. 219). IDPs were physically and forcibly relocated through displacement (and for some, though not this study's participants, through

government evictions). The loss of land, property, and agricultural livelihoods was real, felt, and impactful. The experiences of violence, loss of lives, injury, and war were visceral and detrimental. However, it was the psychological and mental relocations that resulted—the transfer or back and forth of memories, identities, daily living, and community participation from one place to another—that were just as difficult to negotiate. This is the complexity of relocating self and mind along with body.

Struggling Through

The narratives IDPs provided had to do with experiences of displacement, care-seeking, social support, belonging, and health. Although participants described having to contend with particular health and mental health crises and problems, most of the issues that participants described facing were not identified as psychiatric problems and should not be classified as such. Rather, participants' narratives centered on various types of struggles, and on the process of 'struggling through.' 'Struggling through' illuminates the dynamic and ever in-flux experience of displacement, as well as the effort required from IDPs to manage and understand this experience. 'Struggling through' is also a reference to Pescosolido, Garner, and Lubell's (1998) categorization of mental health care-seeking as 'muddling through' a system with unclear entry-points and pathways. Similarly, accessing help and services while living within displacement is an unclear, disjointed process. IDPs described uncertainty about their future housing arrangements and the possibility of either privatization of their current housing or eviction. They also described uncertainty about prospects for integration, the continuance of their status as IDPs, and avenues for accessing services. Mari explains

the struggle of accessing support for problems related to the physical condition of the settlement: *[S]ometimes we run to the Ministry [of IDPs], sometimes again someplace else to do something for this camp site because now overall the communal thing isn't good, sometimes something breaks down, sometimes [electricity] meters aren't good and we run around to bring things in order.*

'Struggling Through' is also about a deeper process and transition. This struggle has to do with a tension between being stuck and immobilized in displacement and wanting to move forward and transition out of this stasis. However, IDPs faced limited options for doing so. IDPs described both a struggle to break free of their current identities as the 'displaced' as well as a yearning to hold onto this label, for it provided them with an emotional link to their pasts, a social link to their friends and neighbors, and an indicator to others of their original communities. This was a desire to both shed the IDPs status and label and a fear of becoming disconnected, isolated, and adrift without it. The IDP status therefore both united people and segregated them—it created community and prevented community building. This was a struggle to move on from the wounds, pain, and loss of the past while holding onto the nostalgia, sense of belonging, and rootedness of homeland. IDPs described the difficulties of and risks surrounding return, as well as uncertainty about the prospect of an official return process, but remained deeply connected to their pasts and unable to move forward.

'Becoming Displaced' and 'Becoming Integrated' can be understood within Braidotti's (2011) analysis and re-conceptualization of nomadic theory. In her application of nomadic theory, becoming has to do with the shifting, cyclical, dynamic and de-centered process of claiming subjectivity, social place, and self-hood. For

Braidotti, becoming has to do with the spaces in between and “the multiple locations of devalued difference,” (p. 30) which can also become “positive sites for the redefinition of subjectivity” (p. 30). Further, becoming is necessarily relational and the formation of identity has to do with interactions with other social actors: “All becoming takes place in a space of affinity and in symbiosis with positive forces and dynamic relations of proximity. This transversal interconnection frames the space of common actualization of alternative modes of relations and affective connection.” Therefore, identity formation and social interaction also rely on emotional and personal connections and relationships. IDP status and the center community provided a sense of shared identity and experience, what participants described as being ‘tied together in displacement’ and a ‘village-like’ environment. However, it was these shared experiences and problems that also created difficulties in individuals’ ability to access social support and create social spaces. The regular, and often daily, sharing of life in displacement mired individuals in their present conditions and made it difficult to imagine an alternative future. Yet individuals also expressed concern about burdening their friends and neighbors with problems that they knew were shared by many, and therefore they sometimes experienced social isolation when coping with the chronic demoralization of displacement.

Despite this shared identity and the support often found within the center community, many individuals expressed a desire to break free and move forward from this community. ‘Struggling through’ involves the desire to integrate within the broader community, as well as a concern for losing the sense of community found in the center and their unique identity as IDPs. Individuals described a desire to transition beyond

their present circumstances, in terms of their housing and status, but felt stuck, as if they were always waiting for an uncertain and unspecified future. IDPs' trajectories and descriptions of their lives in displacement are not linear. Indeed they are rhizomatic, with multiple starting points, dynamic, cyclical and at times contradictory. 'Struggling through' captures the elusive quality of these individuals' experiences of living with displacement, integrating, and becoming.

Ending Up in the Collective Center

The trajectories IDPs described having taken to end up in the collective center were often non-linear, shifting, and dynamic. In both the present ten interviews and the migration histories collected in the earlier round of interviews, individuals described finding their way into the centers as an often chaotic process. Although the collective centers and compact settlements served as shelter spaces for the displaced, there was not often a clear identification of these spaces, quite unlike the new settlements that the GoG purposely built for the later cohort of IDPs, displaced in 2008. Indeed, in some cases, IDPs inhabited abandoned or vacant buildings that were later named collective centers by the GoG. The country as a whole was in a state of upheaval and flux in the aftermath of war, conflict, and regional instability after the breakdown of the Soviet Union. 'Ending Up in the Collective Center' was not typically an intentional choice, although in some individuals' cases, decisions were made to return to or remain in the center. Norms on durable solutions for internal displacement require that IDPs have access to a true set of choices about their living arrangements (Brookings Institution & IASC, 2010). Given the limited housing choices IDPs currently have in Georgia, and the

lack of a safe return option to Abkhazia or South Ossetia, ‘Ending Up in the Collective Center’ cannot be understood to be a true choice. Yet, living in the collective center or compact settlement is the present reality for almost half of all IDPs in Georgia. It is therefore important to understand how residents have adapted to this space and whether the collective center is able to function as a space to support IDPs in their daily lives, support seeking, and the transitional process of ‘Becoming Integrated.’

Participants in these ten interviews lived in two settlements. The first was a government run collective center in Zugdidi. The center was a large, multi-storied brick building a *marshrutka*, or shared van, ride away from the city center. The only other building in close proximity to was another collective center of a similar size. The buildings were located on open plots of land, with a small, quiet street adjacent to it. On each floor were multiple separate units, with most housing a couple or a family. Most units contained one or two small rooms separated by curtains or makeshift walls. There was no running water in the building and residents described carrying buckets of water up flights of stairs in order to cook or flush the toilets. Most residents shared bathrooms located in the hallways. Cook stoves were placed in the hallway and shared as well. The building did have electricity, but hallways were dark, paint on the wall was peeling, water damage was apparent, and the building showed structural problems. Some residents had small televisions or computers in their units. Most had personalized their living spaces with photographs of family members, often deceased, in frames or taped on walls next to other adornments. Overall, living spaces were simple and sparse. The second settlement was a government-run compact building on the outskirts of Tbilisi, the capital city. The settlement comprised several small cottages clustered on a

contained plot of land located next to a busy thoroughfare. Most families were housed in separate cottages, and each building had access to shared land on the settlement. Some residents tended to small gardens they had cultivated. The settlement was physically isolated from other buildings and the rest of the city. The settlement also contained a small, one-room school and meeting space for IDP children. The school mostly functions on the weekend, and residents who volunteer with NGO X teach needle-working, journalism, drawing, and computer skills. However the space is open to children at all times. The space is intended to keep children off the streets while learning useful skills.

The collective center and settlement were not protected spaces for IDPs. Residents did not own their living spaces and lived with an ongoing anxiety about whether they would have to leave, when, and to where. In part due to this lack of ownership and sense of uncertainty, IDPs did not express a sense of belonging toward the center spaces. IDPs were not able to care for or claim their spaces as their own. Indeed, the ease in which government officials, NGO workers, and researchers—including the research team in this study—were able to access center spaces reflects the fact that these spaces were treated as public property. That is, the center tacitly belonged not just to the government but to the broader community, and many outside actors were able to lay claim to its space. Giorgi, a 50 year old man living in the Tbilisi settlement, describes how government workers from a social services agency entered the settlement and forcibly registered a guest as an IDP: *People came from the social agency. . . I told them that they were only guests, they would leave in 10 days, but they said that they needed to write down everybody who was here . . . they verbally abused us, said that*

we were deceiving them, how, 'she was in this social thing' [the compact settlement] and they registered her forcibly. Through housing, relocation, and registration processes, therefore, the government and its representatives assume the right to IDPs' living spaces and identities. IDPs are not allowed the opportunity to shape their own subjectivities within the current collective center space.

In relating their experiences of living with displacement, IDPs did not describe a strong sense of connection to the collective center space other than a temporal connection, though many had lived in the centers for 15-20 years. Some individuals described making small repairs or changes to their spaces over the years. However, a deeper sense of rootedness in, or relatedness to, their homes was lacking. Individuals rarely expressed pride or ownership in their homes. Nana, a 40 year old woman living in the Zugdidi collective center displays this ambivalence as she talks about her living conditions: *Well, we are friendly; we are refugees--it's been 14 years. We got used to each other, but it's still called a dormitory, still. . . The area is large* [she has two rooms], *some people have smaller ones. There's no water upstairs, we take it from downstairs and I brought it up recently with difficulty.* She explains that the collective center brings her *discomfort* and when asked about life in Zugdidi she explains that, *I don't know, when you don't work, you sit at home, it doesn't matter if you live in Zugdidi or Tbilisi. What will the city give you, if you don't have the income?* Nana thus expresses that poor economic circumstances, as well as social isolation, prevent the development of a connection between herself and the wider community and city.

The physical structures and poor conditions of the collective center were not conducive to the development of a sense of rootedness. In the Zugdidi collective center,

some stairways were in disrepair, glass windows were broken, and there was no running water or kitchen space. Further, there were no physical spaces within the center that could be used specifically for social interactions, meetings, or gatherings. Instead, residents tended to spend time in each other's units. Participants also described lacking access to plots of land on which they could grow vegetables or plants. However, individuals in the Tbilisi compact settlement were able to access and till small plots of land where they grew limited crops such as grapes; this produce was cultivated for their own consumption and grapes were often used to make homemade wine, a Georgian tradition. Tamriko locates the difficulty she has in establishing an emotional connection to the collective center in the difference in physical conditions she experiences between her home and other parts of Tbilisi. It is difficult to visit non-IDPs who live in better circumstances. She does not feel that she will be equal to residents of the city until she lives away from the settlement. When she enters the city she feels her misery more strongly, as well as a sense of helplessness and weakness. It is depressing for her to go into shops because she cannot afford the items in them and she feels the effects of her condition more acutely. She talks about having to use firewood to light an oven in the 21st century and having the smell of smoke linger on her when she walks into the city. She expresses embarrassment and even shame by this reminder of her difference as she enters a place in which she feels she does not belong. Tamriko cannot shed her IDP status or sense of being different even when she is physically located within the city--her displacement lingers, like the smoke.

The settlements and collective centers were always intended to be temporary shelter spaces, and participants expressed living for years with the uncertainty of not

knowing when they would have to move, and to where. This uncertainty has increased since 2010 when the GoG began implementing housing policies of collective center privatization and IDP relocation, as part of its national IDP State Strategy. IDPs therefore now faced the possibility that, after 20 years in displacement, the government might relocate them into private apartments. In its initial stages, implementation involved the forced evictions of IDPs who had inhabited abandoned or vacant housing, as opposed to government owned shelters. In the face of international and national criticism, evictions were halted (Amnesty International, 2011). However, not all individuals described feeling disconnected from the center space. Ketevan, a 51 year old woman living in Zugdidi, explains that while she would like to remain within the center, her 28 year old son, who has returned from military service in Afghanistan, does not feel free to get married if they remain in their current cramped living conditions:

I, for example, like this place very much. My son doesn't like it, but I do. I won't have such space if they give us apartments, will I? I have it here, I have the bathroom, toilet, I have everything here, when you go into this direction. And I'm fine with that, for example, and I really like this place but my son doesn't want it and it's not a place for residence they say, and I don't know, they say there will be re-settlement... And if there is, there will be. Whatever happens to others will happen to me too. . . What is this, this is an office, he [her son] says it's an office; that when he brings the wife, she will say that we live in the office and that's why he doesn't like it [laughing].

Several individuals explained that they, or their families, had chosen to remain in the collective center, or had returned there after spending time in private accommodation elsewhere, for example in Tbilisi or Rustavi, a city south of Tbilisi. Teá, a 19 year old university student in Zugdidi who is interested in studying psychology, explains that her family had the chance to live in private housing when they returned from several years spent in Moscow. For various reasons, however, they ended up in the

collective center: *So in my opinion, this is a sudden thing; we also had an opportunity and conditions when we arrived from Moscow; we could have gone someplace else outside the common dwelling, but something, because of some factors we stayed here.*

Irakli, whose family was displaced from South Ossetia in 1990 when he was five, initially lived in a privately owned house in Rustavi. When he was 14 years old his mother passed away and he moved to the settlement to live with his grandparents. Irakli explains that he spent a great deal of time in the Tbilisi settlement as a child and essentially grew up there. At that time, the settlement had electricity and better physical conditions than their home in Rustavi, although presently there are *a lot of bad things* in the settlement. One of these problems, mentioned by several Tbilisi participants, was shared electricity meters. Shared meters meant that any time individual residents were unable to pay for their electricity usage, electricity for the whole settlement was turned off. Irakli also explains that he has made friends in the settlement and has gotten used to it there. Although he cannot imagine living elsewhere, and does not experience any difference in treatment between IDPs and non-IDPs, he says that he is still considered to be a new-comer in the city. However, even if there was a chance to safely return to South Ossetia, he intends to remain in Tbilisi since he is used to the city and the people there. A 29 year old woman from an earlier round of interviews decided to move back to a collective center in Zugdidi with her husband after having lived in a private apartment in Tbilisi for several years. The couple chose to return so that they could live near their family. This young woman explained that while this was a hard decision in the beginning, she had now become used to the more communal life of the collective center, and she could not imagine living elsewhere: *From the beginning it was really hard to adapt. I wasn't*

used to a collective center; I lived in an isolated apartment there [in Tbilisi]. And generally, I didn't have any interrelation with other people. Here we are more like one family. I got used to it. It was really hard at first but now I really got used to this situation, and I even think that I probably can't live in an isolated, normal apartment any more. I am really used to this place. This experience of being “used to” the collective space was a common refrain among participants, who described a connection to their homes by default; that is, a connection to the collective center emerged simply from having spent time there over the years.

The collective center was a flexible shelter space that could allow in and expand to fit waves of movement and transition as IDPs moved in and out of the buildings over time. Tamriko, who was displaced from South Ossetia in the 1990s and lives in Tbilisi, described having family members who moved in with her family in the settlement after they were first displaced during the 2008 war. In the earlier round of interviews, participants described their own or others' experiences with renting out living spaces in the center to non-IDPs from the local community. The collective center was therefore not a fixed space, and this flexibility allowed for the provision of support and shelter to those who needed it. However, while the center could expand and contract as a shelter space, it was not a space that could truly promote the growth of its inhabitants. Many IDPs felt physically, socially, and emotionally stuck within the center. Just as IDPs did not relate fully to the collective center, the center itself was not a space that could fully reach or relate to its residents.

Many individuals described feeling uncertain about their futures, both within the centers and with regard to their lives in general. Years of uncertainty, waiting, and living

in limbo contributed to a sense of helplessness, hopelessness, passivity, and, to a certain degree, apathy. Tamriko explains that for many of the young people in the settlement, the camp space is everything for them, and they have not fully engaged in the wider urban environment. She explains that many people had their work, education, and lives interrupted during the war, and now they live their lives in limbo, stuck, and unable to transition:

Our generation is a lost generation for this state, or personally for me, we are lost, now I'm not talking about myself specifically. I somehow managed and I found my place in this life, yes, but there are people, so to say, who couldn't manage to do anything. So those youth, boys mostly, who were 15-16 years old and arrived after that war; who are those youth? Mostly uneducated because, everything finished for them, studying stopped, then you know what kind of life there was, so they are absolutely uneducated, or thieves, or depended on the drugs, that's it. And their life is nothing. They are stuck, they are frozen in one place.

Therefore, while the collective center was a space that accommodated displacement, movement, and change, it was also a space that fostered stagnancy and hindered residents' abilities to transition beyond their immediate social and economic circumstances. The collective center, as an environment that could not promote positive change or growth in IDPs' personal lives, was therefore a space without intention.

Individuals who had other opportunities for participation in the wider community through jobs, university, or their children's schooling, were able to access the potential for moving beyond their displacement identities. Work and education provided avenues for moving outside the social space of the center and overcoming the stagnancy they experienced there. Teá describes socializing with other IDP and local youth at cafes and restaurants within the city. The four women in the Tbilisi compact settlement all volunteered for a local non-profit organization, NGO X, which provides

services to conflict-affected communities, including other IDPs, in Georgia. Individuals described work and educational opportunities as avenues for moving outside of the social space of the center and overcoming the stagnancy of life there. The ability to become involved in the broader community was difficult for participants, however, because of limited economic opportunities, the geographic isolation of the centers, limited social networks, and health problems. Nana explains that she is not healthy enough to work: *I'm not healthy, [blood] pressure bothers me, I don't know. Poverty, depression, nervousness and I am sitting at home. And now I don't have the experience to stand in the bazaar and sell something and I won't be able to do that.* In addition, individuals faced the psychological barriers of feeling their lives had been interrupted, they were without clear directions or paths, and their futures within the centers were unclear. When asked to consider time spent with friends and life outside the collective center, Nana is not able to as she remains entrenched in what life has been in the center for so long: *I don't know now, I'm so used to those conditions, this life, I don't know.* She explains that what she would like is to live in *normal, regular conditions*, as others do, although she is not able to describe what this involves other than having a toilet and bathroom within the apartment. Individuals felt tied to the collective center space, despite its problems, and not always ready to move beyond it into the rest of the community. In spite of the lack of opportunities and uncertainty about the future surrounding life in the center, it became IDPs' primary social world.

Although growth and transformation does not occur easily in the collective center, it is a space that provides both physical and emotional shelter and that allows for social interaction. As a differentiated space itself, it is a physical counterpart for the

sense of separation and difference that IDPs experience. In so doing, it both accentuates and protects IDPs from this vulnerability, while providing a community of individuals with a shared experience. The collective center therefore provides a sense of identity and meaning in its physical space that fills the void that IDPs experience while living with uncertainty and displacement. Without a pull to the wider community, the collective center provides social support networks and emotional safety. The collective center is a communal space in which individuals regularly cross into the living spaces of close and trusted friends and family without concern. Contact with neighbors and friends occur on a regular, often daily, basis. Irakli and some of his friends from the settlement hang out as a men's group, or "birja" [ბოჯა], in one of the empty buildings on the settlement; they drink beer, play games, and talk. For Nana, the collective center is an uncomfortable place, but it is a place where she and her neighbors have gotten used to each other. After many years, she explains, they still call the building a dormitory. She feels as though her neighbors are an extension of her family. Therefore, the 'household,' in the context of the collective center, consists of the most proximal social network and is usually a combination of family, friends and neighbors. The social household does not always map onto the physical household and indeed, the family unit often extends outward across the collective center space, particularly when actual family members are not present.

Dynamic Relatedness

There is a limited sense of 'Dynamic Relatedness' between IDPs and the collective center space. 'Dynamic Relatedness' has to do with how a space can relate to the social and

psychological needs of its residents. A physical space is not just a shelter space but also has the potential to support the social interactions and personal growth of its residents. There needs to be an active and inter-active sense of relationship between IDPs and the places in which they live in order to support their efforts at integration. Currently, the collective center is limited in its ability to respond or relate to the needs of its residents, and IDPs are limited in their sense of rootedness in, and belonging to, their living spaces. The collective center space provides an opportunity for IDPs to develop and strengthen social bonds amongst themselves, but it limits individuals' abilities to transition beyond their IDP status, develop social networks within the larger community, identify pathways for professional and personal growth outside the context of displacement, and more fully integrate. The collective center space constrains IDPs' personal trajectories within displacement, as well as their identities—always tied to displacement—and for many, it accentuates individuals' experiences of insecurity, loss, and demoralization.

'Dynamic Relatedness' also has to do with the ways in which social connections are created, relationships maintained, and networks forged. Despite the fact that participants are living in a state of stasis within the center, network building is a dynamic process. Seeking care for problems and creating care and support pathways is co-created and thus, dependent on the potentials, experiences, and resilience of different social actors. Some individuals possess greater ability to support others. Lika explains that she and a few other women in the center, including Tamriko and Mari, act as social connectors for other residents by providing support to them and putting them in touch with others who can help them. They also try to get services and help when

there are problems in the settlement; Lika describes how they worked together to try to get a rain flow system implemented to address leaking roofs, although they were unsuccessful. Other residents now rely on these women's help, and Lika feels the pressure of their expectations. In the contained environment of the collective center, the asymmetry in social support potentials and pathways can greatly determine the development of informal care structures and a resilient community. Individuals who regularly provide social support to other community members, such as Tamriko, Lika and Mari, may feel limited in the support they can access for themselves.

Connecting To and Through Land

Having a connection to land, as well as having land of one's own, was a key component in 'Becoming Integrated' for IDPs. The lack of adequate housing or connection to the physical spaces of Zugdidi and Tbilisi contribute to a lack of social rootedness in the community. IDPs did not describe a connection to the physical structures of the collective center or to the land in Zugdidi or Tbilisi with the same intensity or emotion with which they described Abkhazia. Indeed, they rarely described land in the city, although both the center in Zugdidi and the settlement in Tbilisi were located on tracts of land that were more removed from the urban centers of the cities. However, Mari explains how she and the other residents tended to the land in the settlement when they first arrived; they cleaned up the land, removed weeds, planted violets, and continue to grow and sell a limited amount of vegetables. For Mari, she and the others *survived with labor*. Mari also talks about how boiling beans and corn during the war saved her and all Georgians, who equally suffered during the war. Land and agriculture is deeply

respected because it provides them with the means for survival, income, opportunity, as well as social connection and hope. Giorgi and Shota also talk about tending to small plots of land that they have cultivated on the settlement. Giorgi tends to a small vineyard that he has developed on the settlement; he talks about how he loves the vineyard, but there is nothing substantial there because of their limited means. He explains that he *transferred the habits from over there*, meaning that growing grapes and tending to plots were activities he engaged in while in Abkhazia. Indeed, he describes taking care of land as a *religion* in Abkhazia. Through this transfer of physical activities, Giorgi is also, perhaps, transferring his own identity and sense of self to this land and is therefore cultivating his own rootedness in this land. Still, Giorgi remains deeply connected to Abkhazia. Tending to his vineyard may be a way for him to re-establish a connection to his past through the land in his current location. IDPs' relationships with land are therefore multi-layered: working on plots may provide income-generating activities as well as the opportunity for growth and connection in their host communities, and they also provide an emotional link to the past. Working on plots has the potential to bridge IDPs' pasts and their current lives.

In general, there seems to be little imagination of a physical connection with, or ownership of, land in these cities. In part, this is due to the urban environments surrounding the centers, limited physical interaction with plots of land or other agricultural activities, and a lack of ownership of property. However, there is an aspect of this disconnect that goes beyond the effects of living in an urban context. For the most part, when IDPs choose to speak about their connection to land, they are imagining Abkhazia or South Ossetia. Individuals described picking walnuts and fruit,

tending to crops, and fulfilling their obligation to their land. For example, Ketevan explains that while she sometimes thinks she would like to be relocated to private apartments in Poti or Batumi, ultimately she would prefer to live in Zugdidi, even if that means continuing to live in the collective center. This is because of Zugdidi's proximity to the border with Abkhazia; remaining close to it means that she can cross more easily to sell the mandarins and walnuts that still grow on her family's land. Ketevan expresses a deeper connection to Abkhazia beyond this income-generation; however, she remains stuck in the center and unable to transition to a new home because of her emotional ties to Abkhazia. Tamriko fulfills her connection to her agricultural roots in South Ossetia and her desire for emplacement through more modern means. Tamriko tends to a virtual plot through a game on the social network site, Facebook, where she has created a virtual house and farm: *It's because of my wishes. I don't really have a house, right? There, I have built such a house, I have such a plot, I have such things...I probably satisfy my desires with that.*

IDPs also talked about the upkeep and maintenance of their property in their homelands and a feeling that they owed something to this land, which is part of them. Further, they themselves belonged to the land. Teá explains her desire to live in Abkhazia under peaceful conditions because *there's nothing better than that air and soil, really. Land still demands its belongings*. This phrase, the "land demands its belongings" is a Georgian idiom which means that the land calls for or demands its local population to return to it upon death, because people belong to their places of origin. The notion that people belong to their land originated from the idea that each person turns into dirt after being buried. It is therefore tradition that people are buried in their

village or city of origin (Personal Correspondence, Teona Jikia, 9/23/2013). A variant of this is what Giorgi describes, the tradition of having soil from one's village or yard thrown on one's grave. Conversely, IDPs talk about being a part of and living in their host communities; however the land there does not call for them and they do not belong in the same way. There is a sense of obligation, responsibility, ownership, and belonging that IDPs express when talking about land in Abkhazia. Teá explains that she visits Abkhazia and her grandfather every summer and is tied to the land: *I really love that place, those people; it's still our roots*. There is also a strong sense of fecundity and possibility linked to Abkhazia. Despite the risk IDPs described in returning to Abkhazia, IDPs project their hopes and sense of a connection to place onto their homelands and carry it with them during crossings and visits to home villages and remaining family. IDPs' connection to their land is not just physical or familial, it is emotional; this was the site, for many, of their childhoods, their upbringing, and their best memories. Abkhazia was also the site from which everything changed. Shota believes that if the government wants to support the integration of IDPs, they should give small plots of land to each IDP; if this country and its land belongs to everyone, then they should also have access to it. There is a sense, therefore, that to give IDPs access to land of their own would be to acknowledge their legitimate and permanent presence in the community.

Dreaming of Homeland

This construct is closely linked with 'Connecting To and Through Land,' but its emphasis is on memories of the past, grieving for what was lost in the war, memories, nostalgia, and ultimately, aspirations for the future. IDPs' connection to Abkhazia and

South Ossetia is not just about land as birthright and family roots. It is also about the experience of having had one's own home and land. The longing IDPs express when talking about their homelands is thus, in part, based on this emotional experience of feeling like they truly belonged to a community. This kind of connection is supported by cultural values and social roles that have to do with the importance of land, community, and family, but it is made more extreme by the experience of displacement. In addition, many IDP participants in the earlier round of interviews explained that they and many other IDPs lived very comfortably, with large homes, in Abkhazia. This disparity in lifestyle, economic circumstances, and standing in the community after displacement, as well as contending with housing insecurity and longing for property of one's own, made the concept of home and land that much more significant. IDPs therefore expressed a fascination with the concept of home. As Tamriko says: *My dream has always been a house.*

Ketevan explains that when she gets together with her daughter-in-law, they drink coffee and gossip and then *we always talk about things going on there [in Abkhazia], that really, I really have a good house there. And God, if I had this house here, or if I had it in Tbilisi, I would live sitting with my legs crossed after renting it, but where is it? Why didn't they burn it? Why didn't they burn it? Why did they let us go there? When I think about that, I don't want anything here...leave me alone.*

Ketevan expresses loss and desperation over what she had and lost, as well as confusion over why her family's house in Abkhazia was spared and not burned to the ground as her neighbors' houses were. She explains that ethnic Abkhazians had lived in and used their house at an earlier point. The possibility that she might still be able to return to this

house makes it difficult for her to *want anything here*, in Zugdidi. Ketevan's statement also makes clear that when she socializes, the conversation often goes back to their homeland and what was lost. Her nostalgia permeates her everyday life. Teá has a special connection to Abkhazia and visits her parents' village every summer. She feels that she belongs to this land as well: *I belong, something, so your soil, where you were born. Of course, Abkhazia is also my land, and nobody will tell me, no matter where I am, I don't say everywhere that I'm from Zugdidi. I say that I'm from Abkhazia, despite the fact that I don't live there. I have roots there, the village and that's why I say that I'm from Abkhazia. That's why.* Though displacement took away an opportunity for Teá to live in Abkhazia, she re-claims her homeland through her assertions of identity.

Teá comments further on the importance of this emotional connection to homeland. In her view, the older generation struggles more with depression because of their experiences during the war and because they dream of the past: *I'm talking based on my family; they burnt our house twice, and my grandfather died because of that; so his heart couldn't stand it and again my grandmother. . . [M]y father will sometimes say, when he's sad and he says that he wishes he was there and he just smelled that air; he says he doesn't want anything more. . . he dreams about that often, about such similar things and he's like that. It exists in older generation and I feel it indeed.* Teá experiences the nostalgia that her older relatives feel. She describes what it must be like for the older generation to have lost property and their homes: *I'm sure that a lot of people wouldn't be able to overcome it... not my generation, but the older generation, my parents, my parents indeed; imagine now.* She explains that this loss is not just

about the house but about the repercussions of this loss on the family, and she suggests that her grandfather died from this grief. Teá dreams about seeing her grandfather again and looks forward to visiting his grave. The loss of land and property is therefore not just about a physical structure, but about a connection to a community, about community itself, family ties, inter-generational bonds, and tradition. Although Nana believes that it makes more sense for her family to remain in Zugdidi in the long-term, she is nostalgic for Abkhazia and associates it with good memories. This nostalgia for homeland and sense of belonging and ownership is passed on through generations. Mari talks about what her nine year old son told her: *For them now, I was telling them about Sukhumi, now the youngest one proclaimed ‘mommy, let’s go, let’s kick the Abkhazians out of our house and let’s live there.’* For Mari, it was easier to adapt to life in displacement because she did not realize at first that, as she puts it, *Abkhazia would be lost*; rather, she believed displacement would be temporary. The notion that this land has been lost suggests that it now exists only in memories and dreams and that while IDPs still claim ownership of this land, they feel as though it no longer belongs to them. Mari’s connection to Tbilisi is due to it being her capital city, but she explains that will never feel like she is a part of the city because she was forced to live there:

Actually as the time passes... Now my best years, yes, now in Sukhumi [in Abkhazia], 24 years old, everything stays in memories and my little corner. I really loved Tbilisi, as my capital city, but to tell you that I had a desire to live here—I didn’t even think that I could live anywhere besides Sukhumi. . . And I’m always saying that my thing probably, the time stopped there, at the age of 24. And now you just live, somehow; and if I return and if I know that I have a house there and then come back here, this is a different thing, and when you are leaving forcedly, that’s a completely different thing. So you can’t love this place, I do love my capital but I don’t love it as my home. I just can’t, I’m not comfortable. . . I’ll die without becoming a resident of Tbilisi.

Lika's sense of place is somewhat up for grabs. She expresses a sense of being untethered. She greatly misses Abkhazia and thinks frequently about it; her children's lives seem *plain* compared to her own childhood: *I wished there was a return, I would walk back to my Abkhazia*. However her future there is uncertain, and she does not have anyone left there to visit. She also dreams about going elsewhere, to another country, but is not sure her life will be better.

Before moving to Tbilisi, Giorgi and his family lived in Zugdidi for six years. He wanted to leave Zugdidi earlier because the climate was not good for his child's asthma; however he maintained hope that he would be able to return to Abkhazia and therefore stayed close to the border. Health decisions are therefore impacted by a desire to return and feeling unattached to one's present community. Further, Giorgi feels as though he is a temporary visitor in Tbilisi and that he has lost an aspect of his life that he cannot regain: *I, personally, feel the nostalgia for my region all the time. I feel that I'm just a temporary visitor right now; but the years have passed and the life won't come back again for the second time*. His homeland is like an illusion, fleeting and unreal: *[E]verything disappeared like a dream. . . My heart still reaches out there, and the children don't know; it's like a fairy-tale. My mother brought pictures from there too, of the house, but it's like retelling a non-existent story. You should see it with your own eyes, you should experience it, what kind of neighborhood we have*. Although he feels like he is a member of Tbilisi, he does not feel that he will belong to a community until he returns: *The dreams about there [Abkhazia], I'm always there*. He describes how he used to dream about burned houses back home and later saw photos that depicted that this is what happened. Giorgi's nostalgia is thus linked with both imagined and real

traumas. Giorgi explains that in fact, he does not want to feel like a member of Tbilisi because he wants to return to his homeland. Pelkmans (2006) writes that a consideration of cultural commodities is important for understanding how IDPs connect and identify with their ethnic roots in Abkhazia. This ethnic lineage crosses borders and provides a source of connection, but also disrupts a sense of rootedness in their current locations. The orientation to “there” not “here,” affects the creation of social ties and exploration of care pathways into the present community: “Providing group members with a social biography, connecting culture and behavior, past to present. Objectifying culture strengthens the connection between past and present even further, making cultural stuff an important tool in expressing ideas of sameness and difference in a changing world” (Pelkmans, 2006, p. 45).

‘Becoming Integrated’ is made complicated by rejection of present circumstances, as well as by remaining closely connected to memories of the past. Mari’s *best years* were spent in Sukhumi but now, *everything stays in memories and my little corner*. These memories are linked with feeling like she is in control over her own life, which she does not feel currently. Mari explains that when she and her old classmates get together they mostly spend time remembering and feeling nostalgic over their lives in Abkhazia. In contrast, when she spends time with her friends who live in the settlement, they mostly spend time discussing their everyday problems. These friends have bonded and identified with each other over a shared experience of tragedy and feeling of being stuck in their present lives. Mari’s self-efficacy and feelings of hope are therefore oriented to her past. Shota also spends time reminiscing with friends. When he gathers with friends at the settlement, they *sit, talk, remember [their] poverty* and tell stories. His

friendships were established because of shared experiences, and these friendships help maintain a link to the past. In addition, he explains that he and his remaining friends from Abkhazia are connected by an emotional bond. The telling and re-telling of memories keeps the past, and a sense of self that is accepted and more powerful, alive and in the present. Providing and accessing social support is tied up with memories of the past and the problems of the present; IDPs' personal histories and current circumstances are therefore physically and psychologically ever-present.

It is not surprising that IDPs describe an emotional connection to their homelands, as this connection links them with their roots, upbringing, traditions, relatives, property, and family graves. What is perhaps unusual is that when participants spoke about homeland, it was not just a yearning for the past that was expressed, but an investment in, and imagination of, their future. When they described their homes and crossing over for visits, they portrayed a sense of energy, movement, action, and passion. This is in opposition to the more stagnant and idle ways in which IDPs talked about their lives in Zugdidi and Tbilisi. Indeed, Abkhazia and South Ossetia are the sites from which everything changed and, as such, they remain, in IDPs' imaginations, the fulcrum of change. When dreaming of the future, personal aspirations, and transitioning out of displacement, IDPs reference this focal point and, in the process, mentally revisit a time and place to which they cannot actually return. Memories have the potential to help propel one out of the past, integrating past experiences and moving forward along evolving trajectories. This is nomadic remembering, "the active reinvention of a self that is joyfully discontinuous, as opposed to being mournfully consistent...It destabilizes the authority of experience. . . Memories need the imagination to empower the actualization

of virtual possibilities in the subject. They allow the subject to differ from oneself as much as possible while remaining faithful to oneself or, in the other words, enduring” (Braidotti, 2011, p. 229). However, IDPs’ descriptions of ‘Dreaming of Homeland’ were ones where past experiences were dominant, and consequently moving forward was prevented.

Risking Return

Although IDPs’ narratives about Abkhazia and South Ossetia frequently had to do with positive memories of childhood, student years, and family, not all had positive associations. Indeed, many explained that talking about their homelands brought up painful memories from the war and difficult crossings, as well as the reminder that they could not easily return. While Tamriko and Irakli did not describe returning to South Ossetia, the others talked about the risk and danger they experienced when crossing over to Abkhazia for visits to family graves, homes, relatives, and crop maintenance. After the 2008 war and increased tensions with Russia, which supports a sovereign Abkhazia, crossings became significantly more restricted. The Abkhazian side of the border is controlled by the Russian military; Georgians who possess only Georgian passports must obtain a permit to cross over, although it may be possible to cross without one by paying small bribes. However the Internal Displacement Monitoring Centre (2012b) has reported that even with proper documentation, IDPs have faced harassment and violence from border guards, including extortion, random searches, charges of illegal crossings, and detention. The primary crossing point is the Enguri bridge, and participants explained that some IDPs cross illegally by swimming through

the river. Residents of Gali, in Abkhazia, are also restricted in crossing into Zugdidi by Abkhaz authorities; this affects their ability to access social support and connect with family. Further, limited freedom of movement affects the ability of IDPs to carry and sell produce and other goods and also impedes confidence-building across Abkhazian and Georgian communities (Internal Displacement Monitoring Centre). Nevertheless, participants expressed a certain understanding and acceptance of this risk. Despite the physical danger of crossings, and the psychological risks associated with returning to a land where they cannot live anymore, IDPs projected feelings of hope and possibility onto the idea of return and carried this with them during crossings.

Ketevan explains that she is afraid to return to Abkhazia because of the danger in crossing and that her *nerves aren't enough* for the trip to Abkhazia and back. However, she returns because she feels guilty for not using the land and does not want the fruit that grows on it to go to waste. She explains that IDPs continue to have hope for a formalized return, but remain displaced in Zugdidi. This is why she returns: *Now here with their hope, people will probably die and that's why we go there. We are at risk, at risk.* If there was a formalized return, Ketevan would prefer to go back rather than remain in Zugdidi, since Abkhazia is still her homeland. She also believes that she would find employment there, as opposed to Zugdidi, where jobs are scarce. When Nana returns she does so in secret; she travels to her village once a year to visit her parents and other relatives who remain there. Teá also acknowledges how difficult it is to cross over, for example by crossing illegally through the Enguri River. Witnessing the danger of these crossings is impactful: *This is of course such a factor that it influences you psychologically as well, as a person. When you see that a 70-year old woman is*

running, of course, it affects your psyche. She explains that she does not want to return permanently until there is peace between Abkhazia and Georgia and transportation is safe, *like it was before and like my grandmother, grandfather, parents remember it.* As she says, *I will live [in Abkhazia] if there is free travel. I will live there... if there is no fear and there is no life under bullets.*

Everything Changed

Living with displacement, particularly for years on end, means that perceptions of time are less linear. IDPs describe living and surviving the present while constantly locating themselves psychologically in the past. Individuals therefore regularly reference their past identities and lives while living with an uncertain future and a sense of suspension or stasis in their everyday lives. This protracted stasis is in contrast to the dramatic changes IDPs experienced when they were initially displaced. The point of displacement was therefore when ‘Everything Changed’ and a key turning point in IDPs’ lives. As Irakli explains: *It changed, everything turned upside down, and we left.* This was the point that altered the course of IDPs’ lives and, for many, their sense of self, community, and well-being. Some could not recover and remained stuck in their pasts, unable to move forward; others were able to claim a new sense of self even while living in the uncertainty and impoverishment of the collective center environment. However, for all, the point at which individuals and their families were displaced was the fulcrum of change in their lives. This is the point to which IDPs continually return through their memories, stories, nostalgia, grief, and hopes for the future. On the one hand, this is a reference point for locating the self that was disrupted by displacement. Individuals’

identities and personal trajectories are structured around this pivotal moment and the new identity of being displaced. Although this moment when ‘Everything Changed’ has since led to stasis and lives interrupted, it is recalled and understood as a moment of action and change. Consequently, this moment is imbued with the possibility and potential of future change as well. IDPs must locate themselves in their pasts in order to imagine or connect to a future self. The past therefore provides for the possibility of an aspirational self. However, this means that individuals must also refer to a past they describe as having lost or that exists only in a dream. IDPs’ imaginings of their futures are therefore intimately linked with the pasts they grieve, which ultimately complicates their ability to engage with their present and the process of ‘Becoming Integrated.’

Always Waiting

The intensity and emotion with which IDPs described their memories of life in Abkhazia and South Ossetia were not matched by their descriptions of daily life in the collective center and settlement. Individuals expressed uncertainty and anxiety about their present circumstances, which also translated into a feeling of disconnect from their host communities. Although living in protracted displacement was unchanging and static in many ways, it was always accompanied by the threat of sudden change. It was hard for IDPs to claim their homes as their own, invest in their communities and build social networks, or to plan for the future when they did not know what to expect in terms of evictions, privatization, or their status as IDPs. IDPs are ‘Always Waiting’ because they are in limbo and without a clear place in the community. They are ‘Always Waiting’ because of the stasis of everyday life and the chronic demoralization of life in

displacement. They are waiting for a positive change, something better, or perhaps the opportunity to return. And they are 'Always Waiting' because they have lost their homes before and do not know when and if they will have to relocate again.

Tamriko describes how difficult it is to not have one's own space. She is not able to feel free, at ease, or satisfied because of this uncertainty:

[I]t's very difficult to live like this, in these conditions. When you don't have your own thing, you know what kind of feeling this is? It's the moment of waiting and it's terrible that you are always waiting. Today will be like this, tomorrow like that, they will leave it [the settlement] to us and because of that we're always waiting, like we can't be completely open. I can't call it open either, satisfied, I don't know what to call it, there's such a thing when you do not feel comfortable, you feel awkward. I don't know whether I will feel comfortable after this becomes my property, but in any case I have this thing, I have some defect in my heart.

Similarly, Giorgi is not able to feel secure or to invest in his work because of not knowing when they may have to leave the settlement: *Now they will tell us suddenly that we need to empty this space in so many days and they will send us somewhere, and we can't put our heart into our work and we are always like that.* Irakli explains that people are always waiting and wondering whether they will have to move and so they cannot do anything to feel settled in their homes and in the community. They are constantly living in a holding pattern, on edge, and unable to claim control of their lives. Shota lives in fear because of the constant waiting (20 years) and not knowing whether or not they would have to leave. In the end, he wants to be able to stay where he is, although he does not feel as though he truly belongs there. Shota expresses a feeling of desperation and of being invisible. The evictions were very bad, he explains, and the government has created an environment of fear by not providing information about privatization: *[A]ren't the refugees poor enough? Who do we harm when we are here?*

Do we harm anyone? . . . Yes, they [IDPs] have big financial difficulties as well, and when they evict them from one place to another one, they don't want it, there's shouting, screaming, crying, I don't know. The uncertainty IDPs experience also has to do with not knowing what circumstances will be like back in Abkhazia and South Ossetia if they are able to return.

'Always Waiting' led to an experience of being stuck or frozen in place. This is how Tamriko describes other IDPs in the settlement who had their lives interrupted because of displacement and who have not been able to find their place. Shota illustrates his feeling of being trapped in the settlement through an idiom that describes a bird that lives in a golden cage. When Lika first begins her interview, she talks about the life IDPs have had since displacement:

I want to share that our whole youth and the beautiful years passed in such torture, which is called persecution. The only happiness for us is that our children are growing up and we are happy because they study, they are good men, and good women, and I don't know. What else do I want to tell you, that homelessness really affects us. Psychologically we feel that all of this becomes a deposit [alternative translation: leaves deep footprints] in our minds throughout the times. It affects our health too, all of this and... We couldn't manage to realize ourselves, we, probably, our generation. I don't know how others managed this, but those who are my acquaintances, people of my generation, only a few of them are so successful.

She continues on to explain that she and her peers try everything to be successful and to find themselves, but it is difficult, and she is afraid of the future. She feels that everything is changing and developing without her, and she is not able to witness the changes in her homeland: *We can't trace this reality step by step and this hurts me the most.* IDPs watch as the rest of the country moves forward while they remain stuck in displacement. Lika wishes she could do more to help the other IDPs in her settlement. However, the more time she spends with them, the harder it is, because she senses their

stagnancy and idleness: *[When one spends more time with them] then something isn't quite right...I want them to be better, to develop; these people stopped somewhere, they got frozen and I feel sorry for them, you know? We might have been developed a bit more.* She wishes the government would do something for people, *to bring these people out of this bog, to wake them up.* It is not enough to provide food assistance—they need something more. She explains that she does what she can, but it is not enough. There needs to be a strong team in place that will not hurt people as government officials do. She acknowledges that sometimes IDPs act poorly but says it is because of their *disease*. Lika explains that IDPs are not healthy people, suggesting that displacement itself is a kind of disease, and that many of them are out of their minds. Such people, who are not psychologically well, need a different approach.

Tamriko explains that for the most part, *IDPs are very passive*, particularly those her age and older whom she believes have gotten used to others doing things for them. She notes that the youth are more active, as are women, because they are more often employed. She and a few other women in the settlement, including Lika and Mari, are particularly active and willing to help out when problems arise. Lika also talks about being a helper in the settlement and how residents trust their group of women, knowing that they will not turn their backs on them. She used to think that these people were passive and simply asked for handouts from the government; after her daughter fell ill after a car accident, however, she has developed a greater understanding of different people's lives and circumstances. Still, she finds it bewildering that IDPs are happy when they qualify for the social disadvantage government stipend on top of the monthly 22 lari IDP stipend, which she calls a *funny, shameful amount*. She explains that people

sometimes hide their possessions, which government representatives assess in order to calculate an approximate household wealth index, in order to qualify:

So I was thinking, Georgia is in such condition that people dream about being poor and they are happy. For me that is a terrible thing. How can you be happy that you are in a poverty program? They were hiding everything, cars, computers, washing machines, just to be in poverty. So why? I don't understand why? I still can't understand it. Those who are poor, they should be there, right? If you aren't poor, don't be poor. Why are you making yourself poor?

However, as Lika noted, the IDP stipend is extremely limited and inadequate for covering basic needs. Individuals have to find ways in which to supplement their income, including additional government assistance. In addition, IDPs express a lack of agency and note that it is the government that makes decisions. They thus turn to the government for input over the direction their lives will take. Ketevan believes it will be better if the government resettles them into another building, but in her uncertainty about the future she also expresses a lack of interest in this decision, which is out of her hands. However, Giorgi does not believe that the government is invested in the future of IDPs either: *What should the government do? If the government doesn't know what to do, would they believe me? Refugees would have been integrated by now if there was at least one percent desire.* Therefore becoming 'passive' may be a reaction to feeling powerless about one's life, as well as to sensing apathy or abandonment from the government and wider community.

Braidotti (2011) also writes about process, time, and memory. She suggests that from a nomadic perspective, different time zones or moments can coexist in such a way that "activates and deterritorializes stable identities. It also offers a very dynamic vision of the time sequences of memory [see chapter I]. This vision of the subject enlists the creative resources of the imagination to the task of enacting transformative relations

and actions in the present” (p.210). Memory plays an important role for these IDPs, as do notions of time and feeling stuck in place. Neither time nor memory are linear or discrete processes. Rather, memories and moments from the past such as war-related traumas, as well as tentative hopes for the future all coexist in the present moment. Without active engagement with life in displacement, the past supplants and becomes the present. “A nomadic, nonlinear philosophy of time as a zigzagging line of internally fractured coalitions of dynamic subjects-in-becoming supports a very creative reading of memory and of its close relationship to the imagination. This is especially important in the case of negative or traumatic memories of pain, wound or abuse. This sort of negative capital is an integral component of the consciousness of historically marginalized or oppressed subjects” (Braidotti, p.32).

In discussing nonlinear time and memory, Braidotti (2011) refers to both Michel Foucault’s work on genealogy as “countermemories of resistance” and Deluze’s “critique of the powers of dominant memory systems over the human and social sciences” (Braidotti, p. 228). Braidotti identifies linearity as “dominant time,” and becoming as “dynamic time,” the latter of which is required to acknowledge and understand intergenerational relationships, transmission of knowledge, and formation of identity, particularly among people living on the margins (p.228). Dynamic time shapes the processes of becoming and acknowledges that past moments, traumas, and identities can coexist with present and evolving selves. ‘Becoming Integrated’ does not necessitate shedding or moving past earlier selves pre-displacement, nor does it suggest that identities that were interrupted are static and waiting to be re-claimed after integration is achieved. This references Pelkman’s (2006) rejection of the notion that pre-Soviet

nationalist identities were held in a kind of “cold-storage” (p.10). As IDPs integrate and transition out of active life in displacement, they must be supported in the process of evolving their sense of self, belonging and community, which is always shifting.

Living Life at the Middle Level

Living with displacement and in a constant state of uncertainty affected IDPs’ mental health states in different ways, and many expressed chronic demoralization. Eka explains that she lives her life at the *middle level*, meaning that life is neither good nor bad, but somewhere in the middle. She does not have close relationships with friends because she does not want them to tire of her or feel burdened by her sadness. She lives with hope but is not content with her life. However, she does not believe that she needs to feel depressed simply because she is an IDP, and she hopes for the future. Eka therefore wishes to transcend her experience of being an IDP and does not want to remain stuck in her current experience. Nana comes across as reserved and resigned; however, she is also sick on the day of the interview. She explains that on a daily basis, she carries out household chores and *nothing more*. She survives on a pension and aid, since they have lost the bread-winner. *What can I do? We receive social aid, we get books from there and I don’t know, we are in poverty.* However, she describes herself as *probably an optimist* since, despite living in poverty and having three children, she survives and manages. She feels socially isolated and not healthy enough to work because of problems with blood pressure as well as *poverty, depression, nervousness and I sit at home.*

The terms “depression” and “nervousness” or “problems with nerves” were used several times by different participants, without prompting from interviewers. Tamriko explains that all Georgians, but especially IDPs, are currently dealing with *problems with nerves*. Lika similarly exclaims, *We are all on nerves you know?* Her own pain comes from not being able to help other IDPs or poor people emerge from their own unhappiness. She describes other IDPs as exhausted and numb, full of worries and nervousness: *[Y]ou know what kind of faces they have? Washed out, so they are unemotional, somehow, these women are exhausted...It’s very difficult, then sleeplessness, then neurosis*. However, she does not feel like she can express her worries to her family or she will make them feel nervous, as well. She believes that IDPs who live in private accommodation alongside non-IDPs are not as *destroyed* as IDPs in settlements. She feels that it would have been easier if her family had bought an apartment in the beginning, right after displacement, and immediately mixed with people who had not lost everything: *And then it would be much easier for me...I wouldn’t think about the things that I’m thinking about today and what I feel today and I at least wouldn’t have seen all of these, I wouldn’t have seen it with my eyes and I would be in a different world*. The despair caused by displacement is thus pervasive and consuming. Mari describes getting more depressed and experiencing more anger and distress as she gets older. She explains that she suffers from osteochondrosis and headaches, which get worse when she has *nervousness*. Taking care of her husband and children is what keeps her alive. Giorgi has become nervous because of persecution but seems to justify this feeling by explaining that he is a real Georgian man and a patriot. Shota, who fought in the war that displaced him and as a result is physically disabled,

also references the period surrounding the war as persecution. Life since displacement has been *unbearable* and *miserable*. Displacement and economic problems have made IDPs nervous: *People became spoiled because of nerves*. He is not used to life in poverty and disability. His family does not have anything and cannot do what they choose. There is an uncertainty about the future that he cannot think about: *I can't think about tomorrow. What is that like? Yes it's difficult. I don't know what tomorrow will be like.*

Being Out of Place

In their narratives, IDPs expressed a sense of 'Being Out of Place,' because of not having a role in the community, something to do every day in terms of social engagement and economic livelihoods, and not feeling like they truly belonged in the community. IDPs were literally 'out of a place,' given the uncertainty of their housing situations, and experienced a sense of feeling 'out of place.' Emotional insecurity was thus linked with physical insecurity. 'Being Out of Place' has to do with thinking about return, nostalgia about the past, and feeling frozen in place, stuck, and always waiting. When one is 'out of place,' one is without a clear or accepted identity and social position. However, Braidotti (2011) locates the potential of this "in-betweenness" and suggests that the process of becoming must start from the position of "other" or the "non-standard." Braidotti contends that being a minority is the "starting point" of becoming nomadic, where "the nomadic subject signifies both vulnerability and affirmation" (p.41). There is potential in this vulnerability, which is "the transformative power of all the exploited, marginalized, oppressed minorities" (Braidotti, p.41). The process of becoming involves the "undoing of the oppositional dualism majority/minority," (Braidotti, p. 41) or in the

present case Georgian IDP versus non-IDP or local Georgian, and “arousing an affirmative passion for the transformative flows that destabilize all identities” (p.41). Thus, being an IDP, even when this is rejected as an identity, has necessarily shaped these individuals. Integration involves not only physical or even social and economic integration, but perhaps also the integration of experiences of displacement within the self. If adequately supported, it is possible that individuals living in protracted displacement can simultaneously claim and transcend this identity to have it mean something more. “Becoming nomadic means that one learns to reinvent oneself, and one desires the self as a process of transformation. It’s about the desire for qualitative transformation, for flows and shifts of multiple desires” (Braidotti, p.41). The process of becoming is therefore an active process that requires activating and actualizing different parts of the self, including notions of the self and perceptions of belonging anchored in Abkhazia and South Ossetia, as well as confronting the ambivalence some IDPs expressed over the self that has evolved while in displacement. IDPs spoke about their desire to move beyond the confines of the collective center, to do work, be active, and become more.

Emplacing the Self

‘Becoming Integrated’ is an evolving process that is fractured, non-linear, and not dichotomous. As Braidotti (2011) explains, becoming involves desiring the self as a transformative process. For IDPs, becoming involves locating and ‘Emplacing the Self.’ It was not just the physical person that was displaced but the social and mental self as well. For many, this self is still located in Abkhazia or split between homeland and host

community. This is the self that has been irrevocably wounded by displacement but also defined by this experience. And this is the self that does not have a clear role in the community, a secure physical location, or a stable identity and is thus out of place socially, physically, and psychologically. Lika describes the psychological effects displacement has had: *I want them [other IDPs] to be better, to develop; these people stopped somewhere, they got frozen and I feel sorry for them, you know? We might have developed a bit more.* Lika explains that when she spends time with other residents, *something isn't quite right* and she senses their idleness.

‘Emplacing the Self’ is about identifying and developing a path to transcend this stagnancy and involves creating new social roles. Tamriko, Lika, and Mari have perhaps been most successful in creating new social places for themselves, as advocates on behalf of the settlement, through the help they provide to other residents, and through the volunteer work they do with NGO X on behalf of other IDPs. As Tamriko says, *I somehow managed and I found my place in this life, yes, but there are people, so to say, who couldn't manage to do anything.* As a young university student who aspires to work in psychology, Teá has also been able to claim a role outside of her IDP status. ‘Emplacing the Self’ and having a trajectory for one’s future self involves having a secure connection with past experiences and being able to draw on the past as a resource without getting lost or stuck in it. Not having a future trajectory to aspire to is not unique to those living in protracted displacement. Individuals contending with impoverishment, homelessness, chronic illness, addiction and recovery, and mental illness may all struggle with coming to terms with what was lost and uncertain futures. While identity is always in progress, for these IDPs the notion of incomplete identities

also refers to what is missing, left behind, and out of reach. It refers to an experience of alienation and disconnectedness and to a future that cannot be realized in individuals' current circumstances. For IDPs, 'Emplacing the Self' is complicated by living with a fractured sense of the self, split identities and allegiances, pasts that are imagined, glorified and painful, and the chronic demoralization of life in displacement. 'Emplacing the Self' is a challenge, because the self is still in the process of being formulated and understood.

These challenges are not just internal struggles, however, but geographical and political ones too: protracted IDPs still living in collective centers and settlements are living with housing insecurity and uncertainty about their status within their communities. The goal of integration policy is to re-territorialize IDPs into a certain socio-spatial context outside of displacement. In order for this process to occur, IDPs must remove themselves not just from the physical space of the center (i.e. shelter space), but from identities that are tied to this center. This identity is intimately tied to the experience of displacement, as people are 'out of a place,' living temporarily in 'host' communities, and ever waiting to resume their lives in their homelands. IDPs themselves expressed privatization of the collective center or ownership of physical property and removal of the IDP status as necessary first steps for achieving integration. However, Braidiotti (2011) suggests that the process of becoming and becoming nomad is not just of shifting allegiances within groups but of "de-territorialization" or "[individuals] disengaging themselves from a unitary identity as others, which is imposed by their opposition to the majority" (p. 30). In order for IDPs to transform beyond 'Being Out of Place,' 'Frozen in Place,' and in limbo, they must engage with a

continual process of deterritorialization and destabilizing the fixed identity of 'IDP.' Braidotti suggests that this process involves grabbing hold of the chaos of their liminal state and using this new de-centeredness to transition into a new social and psychological space of their own making. This means rejecting the notion that 'IDP' is a binary label (one either is or one is not), a static experience, and necessarily aligned with the physical space of the collective center. Rather, living with displacement and 'Becoming Integrated' are in-flux and dynamic. Deterritorialization means rejecting the attempt to be perpetually categorized as minority or 'other' in relation to the non-IDP majority. For Braidotti, becoming has to do with undoing the asymmetry in power between minority and majority groups or the "center and margins" (p. 30).

'Emplacing the Self' and deterritorialization involves removing the signifiers of difference. Tamriko explains that she does not distinguish between IDPs and non-IDPs, and it is very upsetting that the settlements are segregated in this way. She says that if the government wants integration *then why do you put up this board, you put it like a label that they are refugees. I merely hate the thing that I live in the refugee settlement and in addition to that you put up this signboard, underlining that IDPs live here. This is terrible.* In addition, when she visits her sister who lives in Tserovani, the largest settlement for IDPs displaced in 2008 and located on the outskirts of Tbilisi, she becomes very upset when she sees signs marking it as an IDP settlement. Similarly, Mari feels that IDPs cannot fully adapt to their host communities because they are not heard by the government or included in decisions that impact them: *[W]e're never included and this created the condition that we can't adapt.* Lika explains that the government's relocation of IDPs still involves moving people to new, privately owned, but still

separate housing; she feels it would be better if IDPs were placed in buildings that housed a range of socially unprotected people:

You know they don't integrate; they still settle our people together, take Tserovani as an example, take Poti, take Batumi, this people are still [living] compactly. I don't know, maybe the government needs to have these people under its sight, under its area, so that people are more governable. Probably there are some reasons, because they can disperse people, there are buildings being built. People who are socially unprotected, there are...blocks being built. For example, the Ministry of Internal Affairs is building some right now—they might give out 3-4 apartments to the IDPs and the integration will really happen.

Shota, 55 years old and living in Tbilisi, explains that belonging to Georgia means citizenship, nationality, a link to one's culture and the right to live anywhere in Georgia; he expresses a sense of ownership of all of Georgia. However, he cannot be happy in Tbilisi and the settlement, though it is in Georgia, because *when they kick me out of my region forcedly, I take it differently already. I can't accept it as my happiness and like somebody else's happiness, that's how I perceive it.* That is, this experience and life in Tbilisi does not belong to him and he cannot feel settled or happy with something that is not his. Shota continues: *How should I perceive it? If a man kicks you out of your house and you should think that this belongs to you...* He suggests that living in the settlement feels like being a guest somewhere else, in someone's home. Shota's sense of belonging to Tbilisi lies solely in his being there physically. Yet, he also explains that with this comes a sense of connection to and rootedness in the present moment and his current reality. He expresses some emotional attachment to the settlement: *I will feel sorry if something bad happens here.*

For many IDPs, privatization of their homes in the collective center or ownership of private apartments, as well as shedding IDP status were crucial steps to feeling

integrated in and a sense of belonging to the wider community. Ketevan, a 51 year old woman living in Zugdidi, says that her future plans are to own this apartment if the government privatizes it. Teá, 19 years old, explains that her family hopes for housing they can call their own: *Now this is not our property, it's a temporary housing and I have the hope that there will be something and they will give us something that this will be our own property and not someone else's house.* Teá expresses the feeling that she is living in someone else's house, and others also explained that the center space was not really theirs. Teá also explains that privatization would allow her to live freely in Zugdidi, and that she would prefer to live more comfortably in a place that is not explicitly called a refugee residence: *I think that when you are at home, when it's called an apartment, it's still better.* Thus, the naming of the space and identification of it as something different shapes IDPs' feelings of affiliation to the space and the community, as well as their sense of self. Mari, who is 44 years old and living in Tbilisi, identifies living in a settlement and bearing the label of IDP as key barriers to feeling like a regular resident of Tbilisi: *I've been living here for 20 years really and how can I always be in exile or something? How many years should you live here to start living normally? If they got rid of this [IDP] status, if they privatized this, it would become more mixed.* Mari further explains that if she was able to own her cottage in the settlement, she would be free to sell it and choose where she would live: *I, let's say, don't like the camp site, I like for example Mukhiani, I'll try to buy something there, since I feel comfortable with these people, I have the circle of acquaintances in Tbilisi. Let's say, I'll buy it there, in a word, I'll sell this, I'll buy there. I will be the master of my own self.* Having ownership over one's living space allows for active decision-making and a sense

of control over one's life. When asked what the government can do to support IDPs' social integration, Irakli explains that the first thing that must be done is to hand over ownership of property.

First of all, I think that this territory should be privatized, and then everybody will do something for themselves; they will feel that... You know how it is now? Every day they tell us that we'll move out, move out; people can neither fix the houses to have normal conditions; it's a waste of money, and people are in poverty without that—So they are waiting, they wait and can't really do anything.

A desire for privatization is aligned with the GoG's current integration strategy, although the process has not extended to all collective centers yet. While they are waiting for the process to be completed, IDPs need not feel like they are living in limbo and with the constant fear of eviction. Clear plans for relocation need to be communicated to IDPs living in compact settlements and collective centers. Irakli points to something else that is important to feeling integrated besides privatization. He suggests that feeling integrated and transitioning beyond IDP status is also about being able to *do something for themselves*. Lika also talks about how privatization would allow her to *build a fence, create an intimate thing and I would live as I want, by myself*. Belongingness and rootedness are paralleled by expressions of autonomy, the drawing of boundaries, and assertions of one's own space. 'Becoming Integrated' involves moving out of the holding pattern and passivity that accompanies protracted displacement and, finally, being able to claim one's life for oneself.

For participants, the process of 'Becoming Integrated' was also about navigating their status and identity as IDPs. Participants expressed feeling different and separate from the wider community because of their IDP status. This sense of being different was accentuated by ending up in and living in the collective center. Some individuals

expressed a sense that they would have felt different regardless of where they lived, because they would always be IDPs. For Shota, integration is a psychological process that depends on the person. He feels that there is no choice but to live with others in the settlement and questions whether integration is necessary since: *The refugee will always feel that he/ she is a refugee, those who came from Abkhazia—they always prefer to be there. . . I don't think it can ever happen psychologically. You won't ever feel as a local resident unless you are a child of the region; you always want to be where you were born.* For most, however, living in separate housing and living with the label of IDP increased their sense of segregation and social isolation.

Giorgi explains that the two cohorts of IDPs are differentiated according to who was President at the time of their displacement: “Shevardnadze’s refugees” (first cohort of IDPs) and “Saakashvili’s refugees” (second cohort of IDPs). This differentiation and perceived differential treatment, which was also noted by IDP participants in the earlier rounds of interview, creates additional mistrust of the government and wider community. For Giorgi, the IDP label creates feelings of mistrust, but it is also a source of social protection and services. Accepting and becoming dependent on the status of IDP means giving up choice about when and how the label is applied, for example through registration processes. There is a sense of being constantly monitored and knowing that decisions about IDPs, who one is and what space one occupies in the community, are made by people in power.

Giorgi rejects the label of “refugee” and the notion that he does not belong. In Russian and Georgian, IDPs are commonly referred to using the word “refugee” (беженец/ bezhenets in Russian and ღტოლვილი/ltolvili in Georgian) rather than the

technical term, “internally displaced person.” He explains that he would be a refugee if he was in another country, but he belongs to Georgia: *Starting from Zugdidi, they have put a label on us everywhere. You are a refugee, that’s it. I’m not a refugee, I always argue about that. I’m an Internally Displaced Person. I’ll be a refugee in another country. . . I argue always, but only I can’t change anything, it’s already on the state level, this status of ours.* The GoG does correctly differentiate between refugee and IDP as evidenced by the recent change in the name of the Ministry designated to address this population, from “Ministry of Refugees and Accommodation” to “Ministry of Internally Displaced Persons from the Occupied Territories, Accommodation and Refugees.”

Giorgi, however, expresses a sense of helplessness or a lack of control over his ability to integrate; it is as if others have made the decision, through the imposition of IDP and refugee labels, that he is different and does not belong. The experience of living with the label of IDP means not only feeling as though one is out of place in the host community, but also as though one is a foreigner in one’s own country. Giorgi explains that he feels betrayed by this label and that being called a refugee in your own country affects his psychology and his heart. The impact of this label has devastating effects on individuals’ psyches, sense of inter-connectedness to non-IDPs, and trust in services and the government: *And I mean this psychological thing, they can’t solve this psychological thing; they called us ‘refugees’ and they destroyed us psychologically already; we were without it destroyed; then morally, when they call you a refugee in your own country.* For Giorgi, it is not possible for the government to address or solve IDPs’ mental health problems, because it was the government that put them in this situation and who *destroyed* them and made them feel *secondary*. He laments: *When they call you a*

refugee in your own country, which psychologist will help you then?

Disclosing the Self

Part of living with the status of being an IDP means making decisions about when to disclose one's identity as an IDP, particularly given the feelings of difference and social isolation it engenders. Participants were aware of the power of the label and were careful about disclosure. Tamriko protects her IDP status from other Tbilisi residents, in case she is treated poorly or assumed to be taking advantage of social protections. She explains that others cannot tell that she is an IDP by the way she talks, acts or dresses and that she has never used her status to her advantage or to get a job. She is aware that many others in Tbilisi are economically disadvantaged. For Lika, the identity of being an IDP will always remain. She has some non-IDP friends but senses that they do not completely trust her: *till the end, I'm still a refugee, I'm still an IDP*. However, the 2008 war affected all Tbilisi residents, and she feels that after this there seemed to be an increased understanding of what she and other IDPs went through. Mari interacts with many non-IDPs but feels awkward entertaining them as guests at the settlement because of her living conditions: *I was used to the old life and it's still difficult and it affects my pride as well, what can you do about it?* However, Teá explains that her parents tried to create an environment for her where she felt the same as everyone else. Although she mostly spends time with other IDPs in the collective center, she has *good interactions with everybody*. She has non-IDP friends from her university in Zugdidi. As a child she experienced more of a sense of difference because she went to an IDP only school, as well as prejudice because she was from Gali. Teá explains that she *broke this*

stereotype by interacting with people who treated her differently, and she now feels like everyone else. Unlike Tamriko, however, Teá openly claims her identity as being from Abkhazia, and she tells other people that she is from Abkhazia, not Zugdidi, although she never lived there. Perhaps because she was eight months when her family left Abkhazia and she grew up in displacement, her narrative is focused on her identity as being from Abkhazia rather than as being an IDP. Teá's claim to minority status is therefore based on an identity she can feel proud of, rather than on a traumatic experience. Nana also refers to herself and other IDPs as *representatives of Abkhazia* within their own community.

Concerns over 'Disclosing the Self' does not only have to do with managing the reactions and prejudice of others, however. 'Disclosing the Self' is also a process of managing the pain that surrounds the experience of being an IDP, as well as of making decisions about how to share that pain with others. Mari wants to protect her children from experiencing this pain and feeling of segregation and has them attend regular schools. Earlier her children went to IDP only schools where even the teachers were IDPs, but Mari was concerned that it would be too depressing for her children to be constantly surrounded by IDPs and their problems. She regularly interacts with the parents of her children's classmates, but she does not disclose her status and does not discuss her problems at the settlement. Mari explains that she is already integrated in Tbilisi since she has lived there for a long time, and her children live there. However, living in separate housing and having IDP status still artificially separates them from other Tbilisi residents, who view them as different: *We face the obstacles, we have the pain, but others don't feel it, others don't know how many barriers I have to face and I*

won't start discussing with them. There is a tension between not wanting to be differentiated as IDPs, yet also wanting to be seen and recognized as members of the community who have gone through a particularly difficult experience. This difference in lived experience between IDPs and local residents, as well as the perceived lack of recognition from others about the collective pain of the IDP population is a barrier to integration. 'Disclosure of Self' invites perceptions of difference but also opens individuals up to the vulnerability of revisiting and sharing deeply personal experiences. Lika explains: *I'm probably still different. We are still different, we, we live with our pain, with our nostalgia, we...You should dig deep inside, we have been hiding it so much, so far away that I should dig it out now and tell you.* 'Becoming Integrated' does not mean hiding or shedding memories of the past or the pain of living with displacement. Rather, 'Becoming Integrated' means claiming these experiences and having others recognize them.

Although actively claiming one's subjectivity as IDP is an important step in 'Becoming Integrated,' this process ultimately involves transcending this identity which has been constructed as a majority/minority duality (Braidotti, 2011). IDPs' identities have been shaped alongside and by the collective center community. Their status in the community is defined by their membership in this particular group. 'Becoming Integrated' does not, however, necessitate de-identification from the IDP community; indeed it involves recognition and claiming of shared experiences and togetherness that emerge from living with displacement. 'Becoming Integrated' means claiming the particularities of living with displacement but also moving beyond being an IDP to a new social space.

Transitioning beyond being an IDP is a collective experience. As Braidotti (2011) writes:

“Becoming” works on a time sequence that is neither linear nor sequential because processes of becoming are not predicated upon a stable, centralized Self who supervises their unfolding. These processes rather rest on a nonunitary, multilayered, dynamic subject attached to multiple communities. Becoming...is composition, a location that needs to be constructed together with, that is to say, in the encounter with others. (p. 35)

Lika explains that she will never accept special treatment because of the volunteer work she does. As she explains, all IDPs are in it together: *Wherever the people are, we'll be there too. Whatever the fate of people is, same fate is for us and we never, we, people, God is a witness that no matter what they offer us, we boil in one pot and we'll be together until the end.*

Individuals expressed wanting a new identity that they could claim. However, participants also acknowledged that as a result of living in displacement, they had gone through unique experiences that necessarily separated them from other segments of the community. Tamriko explains the loss of her friendships with non-IDPs whom she had met in Tbilisi when she was first displaced. Part of this loss has to do with getting married and becoming busy with her family. However she also explains this loss in terms of the different social circles that she operates in and the lack of an opportunity to spend time with non-IDP friends on a daily basis, which affects the relationship. She describes an old friendship with a non-IDP woman and explains that they missed important moments in each other's lives and do not have much to talk about. She also explains this loss of friendship in terms of differences in IDP and non-IDP status. She identifies this woman as being “from” Tbilisi and in that statement, an interpretive divide between the two women is already established. In contrast, she describes her friendship with Lika, and explains that they have shared many experiences and they talk

to each other, either in person or over the phone, almost every day. Tamriko explains their friendship in terms of this shared experience: *[S]he is a refugee and I am as well, and we have this same problem of persecution and we are in this settlement. This is a problem of the tribe, it's like we have created a magic circle and there are others like this too.* Tamriko's use of the term *magic circle* suggests that she has been able to integrate her displacement experiences and identity into her sense of self in a way that is more positive and productive in terms of 'Becoming Integrated.' In many ways, Tamriko, Lika, and Mari are a magic circle in the ways in which they have been able to engage with NGO X.

Not Burdening Others

Another aspect of 'Disclosing the Self' has to do with sharing daily problems, psychological pain, and accessing support. Many IDPs explained that they did not want to bother or burden others with their problems. Psychological stress is viewed as something that can be "passed on," and even contagious. Eka explains that she does not want to *spread my sadness over others* or *pass it [stress] to others* so she does not solicit social support but instead stays at home alone and tells herself she must recover on her own: *[W]hen I'm angry, I think that, the stress or whatever it is called, I'm thinking not to pass it to others, that's why I always prefer to start some task, I don't say a word to anybody, nothing and I tell myself, recover from your condition, your stress. . . It's not common for me to make it noticeable when I am angry or nervous.* She does not have close relationships, because she does not want others to tire of her. There is an understanding that sharing problems or being open about one's emotions is

a bi-directional activity between friends, which requires some sort of active support or action. Further, IDPs explained that they were aware that all of them were living in difficult circumstances and shared very similar problems; sharing emotions may remind others of their own problems and be viewed as another burden. As Ketevan explains, *It's not their fault that I'm in poverty...I'm in poverty but I don't show it*. Nana is used to turning to herself in difficult times. Although she feels like she is a member of both the collective center community and the wider community in Zugdidi, she does not feel free to get support from her IDP friends. She explains that other IDPs have problems of their own and *nobody has time for you*. She describes having gone through several depression episodes where she recovered with her own strength and faith and without help from anyone else.

IDPs therefore described choosing to keep their problems to themselves, manage on their own, and to do things for others silently and to *not be seen*, as Tamriko put it. Several individuals explained that others praised them for keeping positive no matter what. Ketevan explains that she feels sorry for everyone and no matter what mood she is in, if people are socializing with her, she feels compelled to be social and happy. Her neighbors tell her that she is always laughing even if she has problems and it is good that she does not make her sadness noticeable. Lika feels that it is not acceptable for her to be in a bad mood. If she is feeling low, she may seek out help from a close friend, her family, or the director of NGO X, though she is hesitant to bother her. In many cases, she feels her problems are too heavy to share with her family members. Generally, if she is feeling low, *she turn[s] to God*, goes to church, visits religious websites, or lights incense and candles at home. She does not want to *surround others with my pain*,

particularly as her friends are themselves suffering; *Asiko's nerves are spoiled; Nana, my friend is also with neurosis*. She describes herself as the strongest among her friends and she knows that her friends would take on her problems and *enter my condition* if she shared them. She wants to make others happy, not sad, and because of this, she feels that she doesn't *have a person to whom I go and tell my pain completely. The only one is God, with whom I always share things and it always calms me down*. Sharing problems is hard because it requires trust and familiarity; however the same sense of shared experience that facilitates openness also causes IDPs to hesitate about seeking support from each other. IDPs have regular contact with each other and display an ease in which they are able to cross over into each other's household spaces for social interaction. However, individuals understand that social, emotional, and financial resources are limited among residents, and do not always share or feel comfortable sharing their problems. Social networks within the center or settlement could therefore not be wholly relied upon, because all members of these networks shared similar problems and were 'Struggling Through.' As Shota asks, *[W]ho can you go to? Who can you ask for help?*

Being Tied Up Together

'Being Tied Up Together' has to do with the closeness or cohesion of the social network within the center and settlement. 'Being Tied Up Together' is a process that evolves over time—it reflects both what stays the same in the social network of the collective center and the dynamism of social connectedness. IDPs revealed that they felt they were necessarily tied together through their pasts, current condition, IDP status, and

therefore in their futures as well. Lika describes this feeling when describing what it is like to live in the settlement: *It's difficult, it's very difficult. Do you know what it is like? People are good, very good, kind, so you love people, I love them too, in this case I'm talking about myself, but we love each other very much, we value each other, support each other in sorrow, happiness. They [other IDPs in the settlement] are honest, orderly people, I don't know; we got tied together very much, and we will be upset if we go somewhere else.* Although it is difficult to live in the settlement, Lika now feels intimately connected to the other residents. IDPs expressed a sense of connection to the center and settlement. They had lived there for a long time and their children and grandchildren had grown up there; many had networks of friends within these spaces.

Most IDPs described their center and settlement communities as a *small village*. The center space supports IDPs like a village where everyone knows and understands each other's problems, even when this is exhausting. Braidotti (2011) writes about the effects of shared traumas on the collective psyche: "I am also convinced that melancholia expresses a form of loyalty through identification with the wounds of others and hence that it promotes ecology of belonging by upholding the collective memory of trauma or pain" (p.320). For example, Shota acknowledges that at least they have each other and are not alone in their experiences, unlike the IDPs outside of settlements. The center has the potential, therefore, to be a communal and supportive living space in some regards. Still, the center was not a preferred living space. Further, living together and sharing histories and problems could be burdensome, as individuals were surrounded by the same displacement-related problems day after day. IDPs are not able to escape the problems of displacement or their status while living in the collective

center. Shota explains that the settlement is not a jail, but acknowledges that he does not frequently leave. He and his neighbors are tied together in fate; because of this, there is mutual understanding of each other's circumstances, and they help each other as much as possible.

'Being Tied Up Together' sometimes involved feeling a close bond with others, while at other times it felt like being chained together and unable to leave. Tamriko explains that the settlement is a place where everyone knows her stories. Though uncomfortable, and at times unwelcome, the settlement is a known entity. Residents trusted that others would take care of them and support them in their pain. The urban environment outside the settlement, however, is unfamiliar and not trusted, particularly in Tbilisi. Tamriko describes Tbilisi residents as being cold compared to the warmth she feels from her IDP neighbors. Physical segregation, social isolation, and a lack of connectedness to the wider community limit the extent to which IDPs access support outside of the shelter space and their IDP networks. At the same time, the settlement is an exhausting place, as Tamriko poignantly describes:

[I]t's difficult and it's good at the same time. We were talking exactly about this one day. When I say that I don't want to live here anymore, I really don't want it, those people's problems have exhausted me, those people's, I apologize for this word and their ignorance and lack of knowledge, and when I get the first chance, I want to leave this place, live somewhere in a normal building, if they gave us the opportunity or evicted us. But then, when I think about it, at some moment, this is a small village. The city has cooled down very much, relationship between people has become very cold and this is a small village, where everybody knows each other, everybody knows about each other; they know my stories better than I do and another point is that if you have a difficulty, there's no way, everybody will support you, everybody will give you a hand. This is good about it; that we all know each other, and people take one another's pain very close to their heart. And I don't know, it's still good. There are bad people everywhere, dissatisfied and such—but overall it's good. No matter who you go to, everybody will tell you that they only want to be evicted

from this place and they don't want to live with anybody, but once they think about it, it's still like this.

'Being Tied Up Together, therefore, also has to do with the fact that these individuals share identities and often feel as though their fates are bound up with each other. As Lika said, she would not allow her situation to improve without ensuring that all IDPs' situations had improved as well. IDPs' collective trauma has shaped a collective identity, sense of community, and interpersonal trust. In acknowledging the subjectivity that has been shaped by shared displacement, IDPs are able to locate their present and future selves in the collective: "The fact that "we" are in *this* together results in a renewed claim to community and belonging by singular subjects" (Braidotti, 2011, p.218).

Seeking Care Spaces

'Becoming Integrated' is complicated by not having permanent physical spaces within the community. Although IDPs felt a part of their host communities to a limited extent, social integration is limited in terms of perceptions of belonging and access to social and emotional support. Although growth and transformation does not occur easily in the collective center, it is a space that allows for social interaction and provides social support. The center is a communal space where individuals can easily cross into the living spaces of close trusted friends without concern. Social contacts are almost always available for social interaction, although individuals are worried about 'Not Burdening Others.' Particularly in the absence of a physical and social investment in the wider community, IDPs rely on the familiar environment of the collective center for social support. Although the collective center and settlement may not facilitate growth or

transformation of self, it has the capacity to provide limited physical, social, and emotional shelter. The collective center therefore became the primary care space for IDPs. 'Seeking Care Spaces' has to do with locating the self in one's community and finding opportunities and spaces to build social support networks. Finding physical and social spaces for care is not always easy. As Pescosolido, Garner, and Lubell (1998) put it, people "muddle through" the process of identifying support for chronic illnesses, including mental illnesses. Descriptions of seeking and accessing support and care permeate IDPs' narratives of 'Becoming Integrated.' This includes accessing financial help, medical care, social support, psychological services, government aid, or simply information about their futures within the center. The process of 'Seeking Care Spaces' is complicated by the physical and social isolation of the collective center and settlement, of worrying about burdening others, feeling passive, not knowing whom to turn to, and feeling immobilized, stuck, and demoralized.

Individuals described accessing neighbors, friends and relatives for material, informational, and emotional support. While many described close friendships, not all felt supported. For example, Nana explains that she has access to information and has not needed that much support. If she needs material or informational support, she usually goes to her brother. However, she might also go to her neighbors for financial help or if she feels sad. Her children and neighbors come to her for material and informational support as well. However, Nana mostly depends on herself: *If you don't help yourself, others are secondary...I have my own hope, in the first place.* Nana does not have an easy relationship with her friends; she describes herself as being alone but also as not able to easily interact with others. She mostly interacts with her neighbors

and does not have time to cultivate relationships outside of the collective center. She is also not able to visit family outside of Zugdidi very often. When Teá needs advice, she usually goes to her mother first, after which she will turn to her friends; occasionally she will share problems with her best friend only, as she does not want to worry her mother. Although she has not yet experienced any serious problems she says that if she did, she would go to her priest. In general she feels free to go to almost anyone around her for support; she feels close to her friends because they prioritize her, as she does for them. Although both her family and friends are supportive, she would not always go to her parents for help with psychological problems, as this might cause them discomfort. Teá gives an example of when she experienced a *depressive condition* when she was taking important examinations. At that point, she urgently needed a psychologist but none were available. She explains that she came out of her depression with the help of her best friends.

In addition to accessing support for themselves, IDPs described the importance of providing help to others and maintaining relationships. This was important, as individuals' social networks were limited yet very important. A number of the women, in particular, explained that they helped others who were having psychological or relational problems. Teá explains that she is interested in studying psychology herself and enjoys giving others advice. Other residents also go to her mother for advice because *she can talk to them, psychologically calm them down, tell them something, for example give them the examples what the things are like and that they should overcome them, they have children and similar things happen, of course*. Teá's mother draws focus to individuals' responsibilities, for example as parents, to help them deal

with personal problems. Lika also views her roles as mother and wife as helping her when she feels depressed. Eka explains that she has a lot of friends and that they care for each other. Several women referred to their close female friends as “sister women” (დაქალოჩკა/ dakalochka). Getting along with each other and taking care of their immediate networks within the center was important.

IDPs described spending most of their time with family or close friends. With the exception of Teá, who is only 19 years old, the women explain that they keep in touch with friends they knew from before displacement and before they moved into the center. They use Facebook and Skype to keep in touch with friends living in other parts of the country or outside of Georgia. Giorgi also describes keeping in touch with his old students through Facebook and Classmates, another social networking site. This is particularly important because he loved working as a teacher but felt that the war and the past presidents of Abkhazia and Georgia took this love from him. He felt supported by others when he was a teacher, and staying in contact with past students reminds him of how he used to feel. Giorgi also explains that he and his friends must show support to each other in non-material ways since they have limited financial means; for Giorgi, this dimension of friendship and providing social support has been lost. Indeed, individuals in general displayed a concern about how to access support from friends and family given their current living situations, limited means, and shared problems. Although individuals had access to social support networks, they described relying on themselves, and being afraid to burden others. Further, the collective center, as the primary social space, is a constant physical reminder of displacement; it contains the traumatic memories of its residents’ pasts and encourages the sharing of common problems. This

psychological immobility is compounded by the physical segregation of the center within the urban environment, the physical immobility of IDPs with chronic illnesses or disabilities, and the social immobility and isolation of joblessness and feeling out of place. Individuals' ability to gain physical, social, and psychological distance from this space is limited. Most IDPs described socializing within the physical space of the center and settlement. IDPs thus locate themselves both physically and socially, in terms of their social networks and their sense of belonging, within the center space. Part of this has to do with how individuals fill their social roles and how the household is defined; the women, in particular, placed emphasis on taking care of their family. Eka explains that her *life is oriented around children*; if she spends time in other parts of Zugdidi, she goes to places that her children can enjoy, such as the museum, the botanical garden, or the movie theater on occasion. Shota as well finds that caring for his grandchildren is a distraction that brings him happiness. For the most part, individuals did not feel that there was place for them in the city. Tamriko spends most of her time in the city at NGO X or at the market; occasionally she drinks coffee and chats with people at shops. But there are not other places within the city that she claims as her own. However, the youngest participants, Teá and Irakli, had wider social networks and more interactions within the city. In particular, Teá regularly spends time outside of the center. She and her friends visit each other at their respective homes in the center or spend time in cafes. However, she emphasizes that there is not much to do in the city and that she limits her time outside, as Zugdidi is more conservative than the capital, and women are not supposed to stay out late on their own: *I've been brought up with traditions and I, for example, wouldn't want anyone to say about me, that what am I*

doing outside when it's late in the evening. IDPs explained that they often do not have the money to spend on restaurants or the theater, as compared to their lives in Abkhazia, which they describe as more carefree.

'Seeking Care Spaces' has several components, including accessing social support, providing support to others, building social networks, maintaining social bonds and relations, and feeling responsibility for the center community as a whole. The latter has to do with the fact that although IDPs did not choose the center space, nor does it truly belong to them, they feel closely connected to other residents and are invested in caring for their neighbors, friends, and families; they are 'tied up together.' However, IDPs do not always have regular access to information, resources, or pathways to formal services. Eka and Ketevan explain that IDPs received more aid when they were first displaced. However they have not received anything for a while except for firewood, which is supplied every year. Ketevan explains how the food is helpful: *Yes, of course, the wood help us a lot. Our stove, my mother-in-law wants it more... since we don't pay money, we will turn on the stoves too; I am fine, but she is old, her bones need warmth and wood is better for us. We're better off when we have wood.* Eka explains that they currently have no running water in the center, and even local Zugdidi residents are having water problems: *The locals themselves don't have water, and how will we have it?* There is an acknowledgement or expectation that local residents will be prioritized over IDPs. Teá explains that each IDP is entitled to receive the IDP stipend of 22 lari a month from the government; Ketevan's husband receives an additional 50 lari a month as a disabled person. Nana calls these amounts a *drop in the sea* and helpful only for emergencies. Health insurance provides complete coverage for medical consultations

but does not cover prescription medication, specialist visits, or surgeries. Most IDPs were not aware of psychological services for IDPs, though most believed they had the potential to be helped; several described problems with nerves or episodes of depression in themselves or their relatives.

Trusting Each Other

Since mental health and psychosocial support was not always available, accessible, or appropriate, informal support structures within the collective center and settlement were crucial in IDPs' social support seeking and management of problems. Tamriko talks about her friendship with Lika, whom she calls her sister woman: *I know this Lika's situation almost as I know about my family's conditions, very well. . I always know now, if there's something that she wants to talk about, she sits with me and talks to me. You know Georgians; we are each other's psychologists.* As mentioned before, IDPs did not always feel comfortable sharing their problems, because they did not want to spread their sadness or burden to each other. Some also felt that it was better to manage their problems on their own and to put on a good face as a way to maintain a social network where all individuals shared common problems. Still, other residents were IDPs' primary social supports. IDPs identified "trust" and "warmth" as key factors in feeling comfortable with sharing problems and accessing emotional support. "Trust" and "warmth" were also important factors for determining social connectedness. Teá explains that she feels connected to Abkhazia because she feels warmth from the people there. Nana also talks about trusting relatives back in Abkhazia: *Moral support, financial support and I completely have their hope.* Mari remembers the time she

spent right after displacement and how she felt *such warmth in my aunt's neighborhood*; it was this neighborhood, and presumably the connectedness she felt, that helped her get through persecution. 'Trusting Each Other' has to do with social connectedness, strengthening bonds, and both accessing and providing social support.

Tamriko explains that she does not trust others easily, and that trust is very important in establishing and maintaining friendships. The problem nowadays is that people are not listening to each other, and this kind of attention is necessary for sharing problems. Tamriko, perhaps, wants to feel heard and listened to. She describes an experience where she was visiting a psychologist who eventually asked her: "Why do you come here, you don't talk to me anyway?" Tamriko explains that when you have not shared a problem, it appears very dark and as though no one else has this problem. But even if you say it out loud once, to someone, you realize that it was not worth so much nervousness. It loses its dark color and becomes easier: *But the thing is that you should say it*. However, it can be hard to share when you are afraid, feel that you cannot trust others, or feel that others are not listening: *People have lost each other's trust. I, for example, have lost the trust*. Trust, therefore, is necessary for the release and sharing of psychological problems. For example, Tamriko explains that: *All the priests have turned into psychologists, because they are only people whom you can trust. You might not trust them completely either*. The loss of trust in each other that she describes impacts individuals' ability to connect, receive and provide support, and build connectedness, both within the center and the wider community. Mari speaks about the importance of warmth in sharing problems; warmth comes from family, friends, and other trusted people. When she is sad, she first analyzes the problem on her own and later spends

time with someone she is trust. When she wants to talk, she seeks out a close friend and describes this as *wash[ing] your heart out with somebody*. When Mari describes how residents in the settlement formed friendships after arriving there, she says that people expressed warmth to each other: *When you feel this warmth, you give it away too*. Friendships were thus established by helping each other out in tough times. She explains that friendship is essentially about trust, support, and ease in sharing. Trust is necessary for talking about *pain in your heart*; it is the *biggest thing*. Irakli goes to his childhood friends for advice, information, help, and emotional support. He is able to share everything with his friends, but feels that he should be helping his family and therefore does not go to them. It appears that for Irakli, familiarity and regular contact facilitates closeness, trust, and social support seeking.

Lika believes that trust is also a key factor for establishing a sense of connection between doctor and patient. She explains that there is a human element to the interaction that requires trust, suggesting a need for a deeper empathic connection. This is why it is difficult to have to rely on insurance where they cannot choose their own doctors. She explains that as a citizen, she should have the *right of choice*. The services that she is insured for are *cheap hospitals and cheap doctors* and she feels this is because good doctors would not agree to the salaries that hospitals provide. As a result, she worries that the care she receives is not adequate. Lika does not trust psychologists and does not use them. She explains that psychologists in Georgia are not well suited to address the needs of IDPs. This is because qualified psychologists need to work with IDPs, but they will not come to them and work free of charge: *And we have huge psychological problems and a simple and non-qualified person might on the contrary,*

not overcome [a person's problems] but do it in the wrong way, as it happened in fact, that was such a case. She describes how psychologists have the potential to cause more harm by not being qualified: *Psychologists used to come here but they were not qualified and they worked in the opposite way; they awoke all the previous pains and my mother got the stroke at that time. I wish they hadn't come at all.* Lika does not have faith in the ability of psychologists to improve people's moods. However, Lika has used the services of a psychiatrist; she brought her daughter to a psychiatrist when her daughter was experiencing a "deep depression" after her accident. She explains that one session cost 30 lari and the doctor provided medication and a follow-up visit. Tamriko also makes a distinction between a psychologist and a psychiatrist: *A psychologist is a person with whom you should talk, and a psychiatrist is the following stage, during madness.* While Lika draws a distinction between these two types of providers in terms of efficacy, Tamriko does so in terms of severity of mental illness. Tamriko explains that she and a neighbor of hers are not able to visit a psychologist because of financial barriers. Lika does not fully trust priests either and considers them to be similar to psychologists: *Just like you can't trust all the psychologists, and all doctors, same way you can't trust all priests.* She believes this is particularly true because people feel afraid of sharing problems with priests. Lika is also mistrustful of the work of NGOs in general and their ability to provide help.

Mari has experienced depression and says *of course* IDPs are depressed. She believes psychological services are beneficial, but not often available. She explains that when she and others first arrived at the settlement, psychologists were there providing help. However, their approach was to have IDPs talk about their pasts, presumably

during the war, and she feels this is painful and not always helpful: *This remembering and such thing might be more traumatic and the psychologists must have a different approach, to help a person find some relief probably, but remembering all of the past is very painful.* She describes her negative experiences with seeking care from a psychologist. She visited a well known practitioner, but received a rude response from the person making her appointment. She explains that this first negative encounter with the staff set the tone for her visit. She was feeling bad and wanted support and found this distressing. Mari also reacted negatively to the psychologist's approach: *When I went there I didn't like her somewhat rude and strict attitude and I imagine a psychologist differently, you know?* When someone is depressed, she believes that the psychologist should be persuasive, inspire hope in the person, *let him/her live until tomorrow*, and should be *firstly kind* and supportive. She explains that a psychologist should distract a person from her thoughts with positivity and should not let the person believe that something terrible is wrong: *You should heal a person with words.* In Mari's case, when her psychologist prescribed medication, it was in a stern, not reassuring, manner and she felt scared. When she tried to make a follow up appointment, she explains, the psychologist told her that she herself was busy and feeling worse than Mari. So Mari stopped taking the medication and never returned. However, Mari needed psychological care then, and even now feels she needs it. Perhaps because of these experiences, she believes that family members are the *best medicine* because they can be affectionate: *A nervous person needs warmth.*

Trust permeates all aspects of support and integration, not just social support and psychological care. Lika explains that the government and Georgian society in

general must trust them and allow them to move on from being IDPs: *You know what should be done? They should trust us. They should give us all our places.* She describes how she took the initiative in the settlement to work on cleaning it up and getting a sanitation system installed. Nobody else was willing to be a leader; she was the first volunteer, and then others like Tamriko joined her. However, trust is required from the government in order for people like her to take action at a higher level. She explains how she has been working with IDPs for 16 years and understands what IDPs need. All residents within the settlement respect her, *but when it comes to my employment, that give a job in this Ministry of IDPs, that maybe I can do better things for IDPs from there, maybe I can do more, Stop! They don't let me beyond this.* Lika wants to be a change agent in her community but feels trapped, because she does not have the right connections. Giorgi does not trust the government to provide psychological support, since he feels that they created many of IDPs' problems. The government needs to organize psychological programs for IDPs. Overall, IDPs expressed that they feel abandoned by the government; for example, they are lied to and promised services during election time; the Ministry of IDPs does not take care of them; the collective center and settlement are not maintained; residents are treated poorly by government workers who count and register them; and stipends are not adequate. They feel that their government has betrayed them by making them feel like strangers in their own country. Further, individuals explained that they do not trust most services available to them, particularly those provided by the state; they feel that the government has demonstrated a lack of interest or care in their well-being. Individuals feel that the government has not supported their integration, continues to segregate them by

maintaining their IDP status, and has them living in fear and uncertainty about their housing. IDPs want to be able to access support from psychological services, but feel that outsiders cannot understand their experiences. Mental health workers can cause more harm than good, particularly if they are authoritarian, rude, or require them to talk in depth about their painful pasts. IDPs want to be able to contribute to the development of their community, but want to be trusted to do so.

Bi-directional Belonging

A key conceptual category that emerged in IDPs' descriptions of support seeking and trusting each other was an implicit sense of belonging. When IDPs experienced a sense of belonging and trust within their social networks, they were more able to engage with contacts and ask for support. When belonging was not felt, care seeking became more difficult. This makes immediate sense with the context of families and groups of friends, where individuals are likely to already experience intimacy and trust. However, IDPs' narratives made clear that experiencing belonging within the center and wider community was also important and predictive of support seeking behaviors.

Many IDPs explained that they felt a part of their host cities mainly because of their physical presence and time spent in them. However, individuals also expressed a sense of disconnect from these communities. Belonging, therefore, becomes more than being part of or participants in a group or place. Rather, belonging emerged as a bi-directional category that involves acts of both giving and receiving. IDPs described belonging as being both part of a place and welcomed into a place. Belonging involved feeling like one had a place and was meant to be somewhere, and this was experientially

distinct from feeling like one was part of a place. As Teá describes when she says that *the land still demands its belongings*, when one belongs somewhere, one both feels drawn to a place or community and is pulled in by the community as well. Belonging is necessarily inter-relational. When considered in light of IDPs' connections to their homelands, 'Bi-directional Belonging' is a multi-dimensional construct comprising: 1) historical connectedness (ethnic or family roots, family graves, customs and traditions, time spent); 2) physical connectedness (location of self, land and home ownership, agriculture, income-generation); 3) social connectedness (social contacts such as relatives and neighbors, social roles); and 4) emotional connectedness (identity, shared experiences and memories, trauma experiences, future aspirations). These dimensions of belonging were not achieved in IDPs' descriptions of their connections to Zugdidi and Tbilisi. Instead, they described a 'default connectedness,' since they felt they had neither full choice over their environment, nor a clear physical or social place in the community. Supporting integration involves creating social roles for IDPs and welcoming them into the community as unique contributors.

Experiences of belonging to host communities differ across generations of IDPs. For example, Shota explains that he cannot feel like a full member of Tbilisi because his father's grave is in Abkhazia. On the other hand, Irakli feels that he does belong in Tbilisi, even though his mother's grave is in South Ossetia. For Irakli, who has spent most of his life in Tbilisi, belonging means spending time in, and being familiar with, a place. Indeed, Mari defines the place to which one belongs as the place where one is born, grew up, and developed one's identity. Having a secure identity is thus part of belonging. She explains that in Tbilisi, *you are nothing* because no one knows you. 'Bi-

directional Belonging' also has to do with how IDPs interact with their social networks and the extent to which they feel like they are a part of and are valued by these groups. Tamriko feels the most valued by NGO X: *I, as a woman, feel the best at work because there I felt a lot of things, attention, respect, appraisal—they value all the nuances which I didn't appreciate in myself and which others don't appreciate.* She explains that her colleagues are the ones who take care of her; for example, when she was sick, they showed the most concern, visited her, and offered help. However, she does not feel the same kind of support in the settlement. There, *they won't talk to you if not necessary.* She explains that some people in the settlement are not friendly, even after living together for 20 years. Nevertheless, she says, *we're tied to one another* because of common problems and the need to support each other for practical purposes, if nothing else. Belonging involves inter-dependence. Tamriko reluctantly admits that she belongs to the collective center, but wants to move beyond her present context.

Lika does not, however, feel that she belongs. She wants to be able to find her place within society, because she is tired of this existence. She likens belonging and membership in the wider community to her relationship with a close, trusted friend, who is also the director of NGO X. To belong somewhere means to *live in the society where there is justice and the law is respected and where you will feel that you are protected, your child is protected, the state takes care of you...how I feel with Nino, well, that's how I want to feel in my country.* That is, belonging is not just about being protected from a legal standpoint, it means being taken care of and valued as a close friend would. Lika's relationship with Nino is one of respect, trust, affection, and maternal care: *I love her like my mother. She'll embrace me and she treats me*

completely differently. Lika also calls Nino *my protector*. Lika wants to experience this kind of protection, combined with beneficence and warmth, from the state as well. Further, Lika wants to ensure that it is not just she who should feel this way; she wants everyone to feel similarly protected and cared for in the country. She suggests that to truly belong requires a collective feeling of safety, protection, and care. One does not fully belong unless one knows that others are also cared for; only then can one feel part of a larger whole. Belonging is about others being well and happy so that one can also be happy: *I want everybody to feel good, so that I'm happy. Will you be happy, if a close person to you is unhappy? You won't be.* For Lika, to belong means to be so bound up with others that you feel your well-being is dependent on the well-being of others around you. 'Bi-directional Belonging' is relational and reciprocal: it allows for seeking care within one's social network and requires a concern for the well-being of others within that network. Belonging at the wider societal level requires this same reciprocity and provision of care from institutions and the state.

'Becoming Integrated' and belonging for IDPs is made difficult by the complexities of the post-Soviet transition. For example, Lika talks about how both she and local residents in Tbilisi went through a difficult experience together and thus have a shared experience. This was also expressed by participants in the prior round of data collection, who all lived in Zugdidi. Thus, IDPs must navigate their own trajectories and transformations out of displacement within the larger context of a country in-transition and the evolution of the Georgian national identity. However, Lika also explains that it is hard to feel pride in Georgia given what has happened to her and other IDPs. IDPs have not been able to connect to "being Georgian" in the ways non-IDPs have been able

to since the break-up of the Soviet Union, since their ideas of identity and community were interrupted during displacement. Further, IDPs must grapple with the complexities of at once feeling loyal and connected to their country, Georgia, feeling betrayed by their government, and wanting to return to Abkhazia and South Ossetia, which feel more like home to them. These regions are contested territories that do not claim allegiance to Georgia at the political level, but are considered occupied by the GoG and as belonging to Georgia. IDPs are torn between geographies and understand that neither their places of origin nor their host communities fully welcome them. Lika expresses this contradiction: *I can't say now that I'm a complete Tbilisian. I'm happy that I'm in my motherland*

'Bidirectional Belonging' also has to do with the aspiration to belong and to be able to claim a community for oneself. These IDPs are nominally and experientially inter-connected, through their present living spaces and daily interactions, through shared nostalgia and displacement experience, and through common fears and aspirations. Within the shared space of IDP status and life in the displacement, IDPs claimed identity through inter-connection and each other's experiences. Braidotti (2011) refers to this collective identity and sense of embeddedness as an "affective, interconnected entity" (p. 311). It is this larger space of connections, networks, and shared (and sharing of) emotions that both enmeshes individuals in each other's shared problems and allows for social support. IDPs talked about belonging, both in terms of how they presently felt or wished to feel, in terms of their homelands, the collective center community, and the wider host community. Being able to claim membership in multiple groups is adaptive: "Migrants, exiles, refugees have first-hand experience of the

extent to which the process of disidentification from familiar identities is linked to the pain of loss and uprooting. . . Multilocality is the affirmative translation of this negative sense of loss” (Braidotti, p. 322). The process of ‘Becoming Integrated’ means more than simply adapting to, or fitting into, the host community. Rather, it is a welcoming of multiple identities and “the process of positive transformation of the pain of loss into the active production of multiple forms of belonging and complex allegiances” (Braidotti, p. 322).

Aspiring for More

Despite the difficulties of living with displacement, IDPs also spoke of the hope they felt for their futures. Some individuals also expressed a sentiment of wanting more from their lives including wanting to transition out of displacement. ‘Aspiring for More’ has to do with this sentiment and the awareness some IDPs expressed of the potential they had to become more. Eka identifies a sense of possibility within herself and her community by distancing herself from notions of illness and vulnerability: *Now if I am an IDP, why should I become depressed and why should I be devastated?* During the war people were depressed, she explains, but she is now focused on her next steps: *I think about building a better life in the future.* IDPs expressed hope for the future of themselves and their countries. For example, Teá is hopeful that *we will live in the peaceful Georgia, that we will be united, I want that most of all really.* She talks of wanting privatization for her family, but she also focuses on personal goals of becoming independent and finding a good job. Indeed, many IDPs located hope in the aspirations and possibilities

of the next generation. Tamriko explains that because parents feel that they do not have anything themselves they push their children to study and achieve.

‘Aspiring for More’ has to do with identifying one’s own potentials and strengths. Lika explains that she has not been able to find a role for herself after displacement but senses the possibilities of what she could contribute: *And I feel as a valuable citizen in my motherland, I don’t feel excluded, I just couldn’t find my place in the society.* Mari wishes for her own apartment so that she can *build [her] life differently*. She thus associates her ambitions and potential with home ownership and physical space. Tamriko, Lika, and Mari are unique, as they volunteer for NGO X and all identify a desire to do more and work on behalf of their fellow IDPs. These women desire to be change agents in their community but seek pathways and social roles that would allow them to achieve more. Braidotti (2011) explains the process of self-actualization as “a composition of passions, intensities, and visions” (p. 33). Further, self-actualization involves reinventing the self and “defamiliarization or disidentification from dominant representational and even self-representational practices” (Braidotti, p. 33). IDPs’ identities are constantly evolving, and self-actualization involves moving beyond a self that is defined both by the state and by loss of home, migration, and displacement. The ability to recognize and identify the self, even when the state or the wider community has not wholly done so, is powerful. Affirmation of self is resilience and involves transforming the negative into the positive and “reintroducing time, movement, and transformation into a stifling enclosure saturated with unprocessed pain. It is a gesture of affirmation of hope in the sense of affirming the possibility of moving beyond the stultifying effects of the pain, the injury, the injustice” (Braidotti, p. 314). Time and

mobility must be handed back to these individuals who have lost time living in protected displacement. ‘Becoming Integrated’ involves helping individuals understand their potential and place outside of the “stifling enclosure” (Braidotti, p. 314) of the collective center. This process involves supporting those IDPs who wish to share their stories of displacement as well as helping them to create new narratives.

What allows for this kind of change to happen is what Braidotti (2011) identifies as “a desire not to preserve, but to change: it is a deep yearning for transformation or a process of affirmation. Empathy and compassion are key features of this nomadic yearning for in-depth transformation” (p. 229). IDPs spoke of a desire for change, both in their circumstances and in their inner worlds. Teá, Tamriko, Lika and Mari in particular, spoke of their desire to make meaning of their experiences as IDPs and to translate that into action by helping other IDPs and engaging with the outer world. At times, however, ‘Aspiring for More’ simply meant hope in the face of hardship. Nana believes she has the strength to survive: *First of all, you should be an optimist, fighter, and everything will be settled, you should have the hope... This life is a battle...I don’t know, I exist.*

Discussion: ‘Becoming Integrated’ and Recovery

Participants’ narratives illustrate that ‘Becoming Integrated’ is a transformative process that affects one’s notions of self, identity, place, and home. ‘Becoming Integrated’ is a process of coming to terms with and transcending one’s displacement experiences. It is a complex and relational process that IDPs co-create amongst themselves as they negotiate their shared histories, collective traumas and identities, and placement within

the wider community. Integration involves 'Getting Used to It,' as well as building social networks, feeling secure and taken care of within one's community (by both social contacts and institutions), and having access to appropriate and effective support services. 'Becoming Integrated' also requires trust in one's most proximal social network, as well as in wider networks and service providers. Participants faced a number of integration barriers, including physical segregation and isolation through residency in collective centers and compact settlements, lack of ownership over property, poor living conditions, and housing insecurity. IDPs assumed a sense of permanency in their circumstances and a loss of autonomy and choice over their lives; this was compounded by the social segregation and isolation they experienced through the continued application of the IDP label. Acknowledging IDP status generated legal protections and social services, national legislation and services, and international recognition and aid. Integration programs, however, must consider how to remove IDP status and help individuals transition into communities, while ensuring legal and social protection. Integration is impeded by a lack of trust in government and social services. Not feeling like they belonged and longing for their pasts also affected individuals' ability to integrate. The effects of war and traumas experienced linger, and IDPs are constantly reminded of their lives in displacement by their physical surroundings and limited social networks. IDPs felt like they did not have a place or a role within the community, as well as a lack of control over their futures. Ultimately, IDPs achieved 'Integration by Default,' due to having gotten used to their situations and having spent considerable time in their host communities. While local integration may not be a truly durable solution, as Ferris (2011) writes, it is an option that allows individuals to rebuild

their lives and as such, should be pursued and supported to the fullest extent possible. Georgia's integration policies need to more comprehensively address the social, psychological, and health experiences and service needs of its IDP population.

Strengthening social connections, and creating social spaces, for example through community centers and associations and community based mental health services, contributes to social reconstruction, recovery (from both displacement and generalized distress), and well-being. Cernea's (2000) Impoverishment Risks and Reconstruction (IRR) model identifies social dis-articulation as a risk to economic and health well-being in contexts of poverty and displacement. To remedy this, he proposes programs that support social re-articulation, which is a "multifaceted process of healing and recovery" (Cernea, p. 364) involving the preservation of community structures, assistance with the development of new community networks, and the "revival of patterns of solidarity and mutual help among people" (Cernea, p. 364). Themes of belonging, trust, social bonds, and social networks were all described by participants as contributing to 'Becoming Integrated.' Badurdeen (2010) identified several "connectors" that facilitate integration, including shared ethnicity, language, and culture, as well as feelings of belongingness and trust. Badurdeen also notes that the integration and adaptation process occurs differently among the younger generation of Sri Lankan IDPs they interviewed. The two youngest participants in this study also displayed a greater sense of inter-connectedness with non-IDPs and social bridging with their host communities, although not necessarily feelings of belonging. Ager and Strang (2008) consider three aspects of social connection in their model of integration: social bonds, social bridges, and social links. Social bonds have to do with experiencing intimacy and connectedness within

groups; in the present study, this might include interactions among IDPs within the collective center or within individual families. Beiser (1993 as cited in Ager & Strang) found that refugees who do not have access to members of the same ethnic group experience a three to four times higher risk for depression than those who do. Social bridges have to do with interactions between displaced persons and their host communities and the extent to which friendliness is experienced and activities shared. Perceptions of friendliness relate to feeling safe and secure, whereas shared activities relate to increased social capital and networks across the community. Participants in this study described rich social bonds within the collective center and settlement and among their most proximal social networks; however, descriptions of social bridges were much more infrequent and limited to descriptions of friendships with non-IDPs, some employment activities, and feeling like one 'got along with' both IDPs and non-IDPs. Finally, Ager and Strang identify social links as having to do with the connection between individuals and social institutions or state structures. Participants described their limited experiences with mental health services, as well as limited access in terms of awareness, affordability, and acceptability of services. Integration initiatives should focus on increasing access to community health services, including mental health and psychosocial programs.

Social connections are not just implicated in the process of 'Becoming Integrated' but also serve an important protective role for mental health outcomes. There is a considerable body of research examining the relationship between social connections, networks, support, and mental health outcomes. Kawachi and Berkman (2001) carried out a focused review of this literature and present four overarching themes that emerged

from this review. They suggest that there are two pathways by which social networks and social supports are theorized to affect mental health outcomes. The main effects model suggests a direct effect of social relationships on outcomes, while the second pathway, the stress-buffering model, suggests a relationship only in times of stress. These two models may be implicated in different aspects of social connections; for instance, structural aspects of connections such as social networks and integration may invoke the main effects model, whereas functional aspects such as social support involve the stress-buffering model. The protective effects of social connections differ across demographic groups. Kawachi and Berkman highlight the example of women in low resource contexts, who may experience increases in mental illness symptoms with more social ties. This is potentially due to increased obligations linked with providing social support and maintaining emotionally close relationships. In addition, women may suffer more from stress contagion, or the stressful effects of others' problems. Some participants mentioned being overwhelmed by other IDPs' problems. More frequently, they expressed a concern that their problems would be *passed on to* others, as well as worry that accessing social support would be burdensome to social contacts.

Kawachi and Berkman (2001) address the ecology of social connections and the embeddedness of more proximal social ties within larger social structures. Lin, Ye, and Ensel (1999 as cited in Kawachi & Berkman) have described what they term the “belongingness-bonding-binding” continuum to conceptualize three levels of social ties and how they function: the wider social community promotes a sense of belongingness and community participation; this, in turn, allows for the development of networks and ties, or bonding; finally, individuals solidify close ties through intimate relationships.

Each level is theorized to independently affect mental health outcomes as well as to have an additive effect on the impact of other levels' effects. Therefore, a sense of belonging or community participation and identity may increase interactions and bonding within groups. The concept of 'Bidirectional Belonging' is suggestive of this continuum, as it has to do with experiencing belonging as emerging out of interaction and reciprocal engagement across social networks. Participants' narratives also suggest that the development of social networks and interactions with social contacts promote a sense of belonging. Interventions that strengthen community-based social support networks may be useful for helping individuals with chronic mental illness. Biegel, Tracy, and Corvo (1994) developed a framework of social network interventions that address the social support needs of individuals with chronic mental illness. The framework suggests three main approaches: building new network ties, maintaining and strengthening existing ties, and enhancing family ties. This last approach is particularly salient in the context of this study, where families are typically the primary informal care-givers for individuals suffering from psychological problems or mental illness. As Biegel et al. note, families play a key role in providing support to people with mental illness, but in the process bear a significant burden and often suffer themselves. Social support interventions should thus be targeted to informal care-givers as well.

Social integration and improved mental health outcomes are associated with perceptions of place attachment and conceptions of home. Sense of belonging is necessary for psychological well-being and is dependent on close social relationships developed in supportive places (Fullilove, 1996 as cited in Hess, Malilay, & Parkinson, 2008). Disrupting place attachment and identity has traumatic effects on individual and

collective psyches as well as a range of negative health effects. Such disruption also adversely affects a community's capacity for resilience and recovery from disaster (Hess et al.). Effective integration policies must address the housing of IDPs, as well as the feeling of "being home," in order to emplace IDPs into the community and improve overall well-being (Badurdeen, 2010). Vandemark (2007) writes about place, identity, and belonging in displacement and uses homelessness as a case study. She argues that promoting a sense of belonging also promotes overall health in the community and that belonging is experienced within the context of social networks. Attachment to place or one's location is central to self-identity, sense of belonging, and self-efficacy. Recovery from displacement is a process grounded in the resumption of everyday life (Almedon & Summerfield, 2004). Therefore, it is important that displaced persons have a sense of connection to their environments, develop social networks, and attach to place. One of the effects of urban poverty on mental health is social fragmentation, and social exclusion through lack of community participation may increase risk of poor health outcomes (Harpham, 2007). Tuan (1977) argues that daily travel or movement reinforces concepts of home, and return to home is a return to a familiar space. What is familiar and a sense of home, then, lies in the past. IDP participants located their notions of home and belonging in their pasts. While participants' present conditions have been defined by movement, they currently do not have places to "move to," both in terms of engagement within the community and the sense of daily return to home.

'Becoming Integrated' is not only a process of social cohesion and engagement with the wider community. It is an active claiming of one's subjectivity defined by displacement, uncertainty, and trauma. It is a process of becoming nomadic, as

Braidotti (2011) advocates. However, it is not enough to claim a nomadic or de-centered consciousness (Braidotti), nor should the marginal figure be romanticized (Cresswell, 1997). Although it does so through a process of categorization and control, the state has the capacity to ensure protection for marginalized groups, for example through the provision of the IDP label or social services and stipends provided by the GoG. IDP participants were forced migrants but are not yet ‘nomads’ in the sense that they remain linked to a particular locale and identity. Developing a nomadic identity would involve claiming this past and identity as an IDP, while not being defined by the IDP category or a proscribed trajectory. It involves embracing their in-betweenness and allowing for multiple spaces and trajectories to take shape—not all IDPs will transition or become integrated in the same manner, while some will not at all. The nomadic identity is not a fixed identity and acknowledges the becoming space that IDPs, as migrants without homes, have entered into, albeit unwillingly. It allows for a new imaginary of ‘Living With Displacement,’ that is, a particular experience that has shaped sense of self, community, and aspirations, but which can be managed and can allow for an as-yet-undefined social space and identity towards which to move.

Conclusion

This analysis has considered the process of ‘Becoming Integrated’ in response to life in chronic displacement among a group of long-term IDPs living in urban government shelters in Georgia. The process of local integration and transitioning out of displacement should be understood to be a dynamic and evolving process which, while lacking in clear endpoints or markers, still involves identifiable sub-processes. These

sub-processes were described by participants as social and psychological experiences of emplacement, self-identification, belonging, and creating social bonds and support systems. Recovery in chronic displacement is also a process of reclaiming identity, place in the community, and hope for the future. These sub-processes have implications for how formal social and health services are accessed. A strong sense of community belongingness and solidarity among individuals greatly influences the kinds of help individuals have access to and utilize in times of crisis; mental health problems are one such crisis. Policies and programs that seek to improve community mental health services for IDPs and to increase care-seeking behaviors must consider the role community participation and belongingness plays. Further, mental health and psychosocial programs within the context of chronic displacement should focus not only on war-related experiences and consequent difficulties, but on rebuilding connections and hope; utilizing a recovery in mental illness approach would be useful. Similarly, local integration policies and programs must address not only geographic relocation or livelihoods programs, but social roles, creating social spaces, and building social networks, as well. It may be useful to conceptualize integration or recovery in displacement in terms of stages of displacement and thresholds of change, for example with regards to social inclusion, social roles, and social participation. Finally, programs that allow displaced persons to utilize their unique skills and experiences, both within the community and in programs that serve other IDPs, as well as programs that provide a forum for IDPs to share their personal experiences within the community, might be considered.

Tables

Table 4.1. Demographics for Sub-set of Participants

No.	Pseudo-nym	Gender	Age at Time of Interview	Region of Displacement	Current Location	Years in Displacement at Time of Interview
1	Eka	Female	37	Abkhazia	Zugdidi collective center	23
2	Ketevan	Female	51	Abkhazia	Zugdidi collective center	20
3	Teá	Female	19	Abkhazia	Zugdidi collective center	18 - 19
4	Nana	Female	40	Abkhazia	Zugdidi collective center	22
5	Tamriko	Female	44	South Ossetia	Tbilisi compact settlement	22
6	Lika	Female	42	Abkhazia	Tbilisi compact settlement	16+
7	Mari	Female	44	Abkhazia	Tbilisi compact settlement	20
8	Giorgi	Male	50	Abkhazia	Tbilisi compact settlement	19
9	Irakli	Male	27	South Ossetia	Tbilisi compact settlement	22
10	Shota	Male	55	Abkhazia	Tbilisi compact settlement	19

Chapter 5. Narratives of Mental Health Care-Seeking among the Long-term Internally Displaced in Georgia

Abstract

This study presents three narratives of care-seeking behaviors and trajectories for mental illness and psychosocial problems. Trajectories of care and recovery are ongoing and incomplete processes that are co-created by individuals, their informal support systems, formal care-givers and treatment contexts, and broader social systems. The three narratives analyzed in this study were drawn from a sample of 39 adult long-term internally displaced persons (IDPs) in Georgia. Participants lived in the western cities of Zugdidi and Poti. Narratives examined participants' experiences with schizophrenia, depression, and inter-personal problems. Different dimensions of care-seeking (i.e. problem description, thresholds, timing, turning points, treatments, household and social support, and trajectories) were compiled into a matrix. Interviews were open coded, and codes were linked with matrix dimensions to construct each narrative. Findings demonstrated that participants moved cyclically between self-care, household support, lay care, and formal services domains to understand and manage their problems. Readiness to access help was an important facilitator of care-seeking behaviors. Processes of displacement and mental illness intersect at various points, including in the recognition and perceived causes of illness, stressors such as discrimination, the affordability and availability of services, and social support networks. Interventions are needed to support informal care-givers, identify intervention points within care-seeking trajectories, and to build lay referral networks to facilitate the transition from informal to formal care.

Narratives of Mental Illness Care-seeking Behaviors and Trajectories

This chapter presents three narratives of care-seeking behaviors and trajectories for mental illness and psychosocial problems among a sample of long-term internally displaced persons (IDPs) in Georgia. Through the presentation and consideration of these narratives, this study aims to examine 1) thresholds for seeking care, including recognition of problems and decision-making processes, 2) timing of illness onset and seeking care, 3) turning points in the illness experience and care-seeking process, including moments of crisis and recovery 4) treatments sought and used and experiences with them, 5) household and social support, and 6) trajectories of care and recovery. These aspects of care-seeking were identified as important to examine based on reviews of the mental health care-seeking literature and components of Pescosolido's (2006) Network Episode Model Phase II (NEM-II). This model of mental health care-seeking emphasizes aspects of an individual's illness career such as timing, treatments utilized, and an individual's social support system. Further, the model considers care-seeking to be a dynamic and cyclical process. Thus, in this analysis, 'trajectories' of care-seeking and recovery are considered to be shifting processes with which individuals engage. Trajectories of care and recovery are ongoing and incomplete processes that are co-created by individuals, their informal support systems, formal care-givers and treatment contexts, and broader social systems. The domains identified above were compiled as a matrix of mental illness care-seeking and applied to the data during analysis.

Methods

The cases selected for this analysis were part of a larger sample of 39 long-term Georgian IDPs from Abkhazia, ages 18 and older. Participants resided in the northwestern city of Zugdidi or in villages surrounding the city; the majority lived in government shelters known as collective centers. These centers were purposively sampled to represent different building types, sizes, and locations within the city. Participants were selected within centers using maximum variation and chain sampling approaches. The sample also included nine individuals who had accessed care from either a state-run outpatient psychiatric unit in Zugdidi or a non-governmental organization (“NGO Y”) in Zugdidi providing psychosocial and psychological services to IDPs in the area. These nine IDPs were selected using a chain sampling approach with a representative clinician from each provider as the seed; some of these IDPs lived in private accommodation within the region. In-depth, semi-structured interviews were carried out in 2011. Interviews were approximately 60 minutes in length and were carried out in two sessions per person. The guide was iteratively developed and consisted of several modules including migration histories, conceptions of mental health and symptom recognition, social comparisons of distress, social support, and care-seeking. Interviews were mostly conducted in Georgian; some participants spoke a mix of Georgian and Mingrelian within the interviews. Mingrelian is a Kartvelian language related to Georgian, which is spoken in Abkhazia and the Samegrelo region of western Georgia. Interviewers were two female Georgian research assistants trained and supervised by the author, who accompanied them on field visits. All interviews were digitally recorded, transcribed, and translated by the research assistants and a Georgian

translator. Debriefing and reflection sessions were carried out after each day of interviewing. Interviews with key informants contributed to a process of expert checking of emerging findings. Credibility of results was also supported by a member checking process with a different sample of ten IDPs in 2012. The study protocol was approved by Institutional Review Boards at the Johns Hopkins Bloomberg School of Public Health and the Georgian National Center for Disease Control and Public Health.

Three interviews were selected for inclusion within this analysis out of the subsample of nine IDPs who accessed formal services. Interviews were selected that were rich in narrative presentation and diverse in problems presented, type of care sought, and recovery trajectories. The selected interviews were open coded to allow for key emergent themes to be identified. Open codes and associated segments of text were linked with dimensions within the matrix in order to construct each narrative. Interviews and open codes were also reviewed in light of the constructs that emerged from the analysis in Chapter 4 in order to make broader statements about emergent patterns. This also allowed for a broader contextualization of episodes of mental illness or psychosocial problems. This analysis aims to shed light on the process of finding and accessing mental health services in the Georgian context and among a disadvantaged population. It does so through an in-depth examination of three individuals' illness and treatment histories. In so doing, this analysis will contribute to an understanding of how IDPs living in urban protracted displacement contend with psychological struggles and illness.

Narrative 1: Yulia³

Background and Problem Description

Yulia is a 26 year old woman suffering from severe schizophrenia. Ia, 22 years old, is Yulia's younger sister who was interviewed as a proxy as Yulia was too ill to participate in an interview. The interview focused on Yulia's illness, but also explored Ia's experiences as an informal care-giver to Yulia, as well as Ia's perceptions of life in displacement and conceptions of mental illness. Ia, Yulia, and her family live in a collective center in Zugdidi. They ended up in the collective center after being displaced from Abkhazia in 1991, living in the city of Kutaisi in western Georgia for seven or eight months, and then living in a village outside Zugdidi for five years where living conditions were very poor. After that, they settled into their current space, a collective center that has not yet been privatized by the government. Ia is pursuing a masters degree in law.

Ia describes Yulia's normal routine, behaviors, and symptoms. Yulia typically starts the day off badly; she wakes early, eats quickly, and is given medication by her family right away because without it she becomes "terribly aggressive." Yulia fights with, shouts, and swears at family members on a daily basis and sometimes runs outside into the yard they share with their neighbors. Yulia eats frequently throughout the day, increased appetite being a side effect of her various medications, and on occasion, she watches television or reads stories or poems. She walks without purpose around the house and in the yard, talking about people, inventing stories, and remembering old

³ All names are pseudonyms

experiences; her memory is very good. Her family brings her to church on a weekly basis unless she is acting particularly aggressive, in which case her family deems it inappropriate to bring her into public. At eight or nine o'clock at night, Yulia is given the second dose of her medications, and she goes to sleep.

Yulia frequently hears voices, as Ia explains: “sometimes she says that there’s a woman in black . . . then there are things that she invents that someone told her something, someone gave her instructions and mainly these are lies, this is all her fantasy.” Yulia also experiences hallucinations and hits herself. She is not fully functional, cannot live on her own, and cannot carry out daily chores like washing dishes, which she often accidentally breaks. Yulia is often depressed during her “bright periods,” as Ia calls them, which often occur in the aftermath of explosions or fights. At these points, Yulia enters a short period of lucidity and has insight about her illness. She calms down, speaks quietly, and becomes depressed, asking: “‘why did it happen to me’ and she’s not satisfied with life and ‘why can’t it be so? Why am I predestined? Why doesn’t any medication help?’” These periods usually last between 10 to 30 minutes. During this time Yulia also converses with her family and speaks seriously about family matters. During calm periods, she also often comments on current political issues, which she hears about by listening to the radio, although she is not always coherent.

Thresholds

At first, Ia explains, she and her family found her sister’s behavior to be strange but a normal part of being a teenager, particularly because of what they had experienced during the war. Economic difficulties and not having enough money for food or for going to a doctor was a barrier to recognition of Yulia’s illness; the family’s severe

economic problems distracted them from paying close attention to Yulia's condition. Further, her family attributed Yulia's unusual behaviors to the effects of the war and believed that Yulia would return to "normal" eventually. Ia strongly believes that the war led to Yulia's illness: "she saw a lot of things by the 3rd grade and maybe she remembered it and such a radical change was hard for her and maybe this is the only reason, I don't know. As I told you, not everyone takes the misery after war the same way and [Yulia's] disease added to this grievous situation." Her family and her neighbors explain the onset of Yulia's illness as "fate," and Ia relates that her family has not been able to identify other extended family members, including in previous generations, with schizophrenia.

Yulia's parents first decided to visit a psychiatrist in 2000 after her behavior and symptoms had continued for a while and were getting worse. Yulia had started crying for no reason, not sleeping for long periods of time, and was getting irritated by everything. She was 15 years old and was pulled out of school. At first her family tried to treat her on their own but after folk remedies did not work, they immediately took her to a psychiatrist and later, to a psychiatric hospital. Although Yulia remembers her time in the hospital positively and remembers the other patients, her family saw that the conditions there were poor. Sometimes they consider putting her into inpatient care for the long-term but they do not feel they can given the conditions and the fact that she is still a family member whom they love: "We've had the question of taking her someplace, but it was only talk because she is really your flesh and blood and you can't just sacrifice her, she's not a useless thing which you're fed up with and you can throw in a garbage

can.” From hearing the experiences of others, the family also does not believe that inpatient care would help Yulia recover.

Ia has experienced a feeling of being different because of her sister’s illness and explains that it was difficult for her family to access care at the hospital because of the stigma attached to serious mental illness: “They still look at such disease with offense in our country; they call it offensive names like ‘crazy’ [გოჯო/ gizhi] so none of the families would be happy with that label and no matter how hopeful they were that a persona will recover in dispensary, nobody is still happy with that.” Making decisions about accessing formal psychiatric services, particularly in hospital settings, is thus influenced by social perceptions of mental illness. Having hope for recovery also requires acceptance of perceptions of difference and feeling stigmatized. Yulia too, in her moments of lucidity, feels different and as though “life rejected her.” Still, Ia is comfortable with disclosing her sister’s illness and does not hide it or find it embarrassing: “this is just a disease, like any others, just a bit worse and aggressive; other than that it’s a normal disease like every other illness.” She identifies schizophrenia as mental disease that is connected to the brain and that is like any other organ disease.

Timing and Turning Points

A key turning point for Yulia was when her family took her out of school in the 9th grade because she was not functioning fully, communicating well, or studying successfully. It was at this point that Yulia’s family began to pay closer attention to her symptoms, which were getting worse, and decided to seek professional care. When Yulia was first

taken to a psychiatrist when she was 15, she was diagnosed with depression. As time went on, and her situation worsened, she was diagnosed with schizophrenia. Two years later, Yulia attempted suicide by first slitting her left wrist and then later, her throat. Her family subsequently took her to an inpatient psychiatric hospital for 20 days. The hospital is located 105 kilometers (66 miles) away in Kutaisi, Georgia's second largest city; by shared van, or marshrutka, it takes about 1.5 hours to travel there from Zugdidi. There is no inpatient psychiatric facility in Zugdidi, although there is one in Senaki, a small city in between Zugdidi and Kutaisi; it is unclear why Yulia's family chose the facility in Kutaisi, although it is likely that they were directed there by Yulia's psychiatrist. Yulia's family expected her illness to be temporary and believed that it would be resolved in one to three months or a year at the most.

Treatments

Yulia's family has tried a range of formal services, folk remedies, and other forms of care to address her illness. At first, her family tried caring for her on their own by giving Yulia folk herbal remedies, but after a week of no change in Yulia's symptoms, they gave up on trying to help her themselves. These folk remedies included tinctures of chamomile, valerian, and mint. Ia explains that after they understood the severity of Yulia's illness, her family recognized that these remedies were ineffective: "The disease is so strong, chronic and dangerous that it's funny to use the tinctures to calm the diseased after such a diagnosis." Ia has a neighbor who experienced some of the same symptoms Yulia first displayed, of crying and acting erratically, during an episode of *batonebi* [ბატონები]. In Georgia, *batonebi* is the name for childhood infectious diseases

such as measles, mumps, and chickenpox; in Samegrelo, the region of Georgia in which Zugdidi is located and which also crosses over into Abkhazia, *batonebi* can also refer to unexplained episodes of severe psychological distress, psychosis, or spirit possession.⁴ Ia's neighbor was able to resolve her *batonebi*—in this case, unexplained or psychotic behaviors—using *mokhvetse* [მკხვეთსე]. This is a folk method that typically involves paying individuals, called *mokhvetse*, to perform rituals such as lighting candles and saying prayers in order to drive the *batonebi* spirits away from the afflicted person; although this invokes religious practices, it is rejected by the Orthodox Church. Yulia's family tried *mokhvetse* when the medication was not resolving her problems, but it too was unsuccessful. Her family considered other folk remedies as well. They were willing to try all possible treatment modalities, if they could afford them, but soon realized that most did not work. They therefore invested time and effort in seeking psychiatric care.

Yulia's family sought care from several different psychiatrists and psychologists. They have a primary psychiatrist in Zugdidi, who prescribes Yulia's medications, but they also visited several psychiatrists in Tbilisi (the capital city) to try to obtain different

⁴ *Batonebi* [ბატონები] literally means 'Lords'; the term can also mean 'sir' or 'gentleman' but in this context it should be translated as 'Lords.' According to interviews with two key informants (a Georgian psychiatrist and a Georgian ethnologist, both of whom have studied *batonebi* in depth), the application of this term to infectious disease refers to earlier conceptions of childhood diseases as something sent from God or the angels. In part, this was due to the observation that a disease such as chickenpox was experienced once and immunity was then acquired; however the disease's infectious nature meant that many people experienced it. The illness was therefore understood to be a debt to God that all individuals had to pay. In Mingrelia, *batonebi* became associated with psychological stress reactions to hardship and difficulty, particularly during times of war, as these reactions were difficult to name or conceptualize. Severe psychological reactions were identified as *batonebi*, through an attribution of these reactions to God and an understanding that God had sent these experiences to them.

medications. Traveling to Tbilisi can take anywhere from five or six hours by marshrutka or eight hours by train. A marshrutka ride costs 30 lari (approximately US\$18) roundtrip, while a second-class train ticket costs 22 lari (approximately US\$13) round trip. As a comparison point, the monthly stipend IDPs receive from the GoG is 22 lari. Tbilisi is located 332 kilometers (206 miles) away from Zugdidi. Ia describes her experience with one of these psychiatrists as being unhelpful, as the psychiatrist did not provide her family with hope:

[S]he didn't say that 'oh, bring her to me, and oh, I'll cure her' nothing; she just stayed still and coldly sent me off... strong and good people because we haven't sent her to a psychiatric hospital... And such words from a psychiatrist surprised me so much... She didn't give me hope or anything, didn't say to bring her and try. That's why I haven't tried to contact her.

Ia expresses a sense that her family feels isolated and unsupported in caring for Yulia. The family also saw a psychologist in Zugdidi, but Yulia's condition was too severe; Ia differentiates between these two types of providers: "It was a problem for a psychiatrist and these two fields are very different from each other."

Yulia regularly sees a psychiatrist at the outpatient dispensary in Zugdidi. At home, Yulia takes medication on a daily basis; she has been taking the same combination of drugs for twelve years. Without this medication, Ia does not believe that anything would help her. However, the medication is limited in its effectiveness. The side effects of the drugs are strong and leave Yulia with a blunted affect and slowness of movement. The family thus feels sorry for Yulia and often only gives her two doses a day instead of the prescribed three. Ia explains that they give Yulia the medicines that they get free from the outpatient dispensary in Zugdidi, which consists of the anti-psychotics haloperidol (Haldol), trifluoperazin (Triftazin or Stelazine in the U.S.), and clozapine

(Azaleptin or Clozaril in the U.S.), which Ia describes as a sleeping pill, as well as an antispasmodic drug trihexiphenidyl (Cyclodol). Haloperidol is part of an older generation of so-called ‘typical antipsychotics.’ Clozapine is part of the second generation of antipsychotics called ‘atypical antipsychotics,’ developed in the 1990s. It is often used as a last resort with patients who have not responded to other anti-psychotic medications. This is because use of clozapine is associated with increased risk of agranulocytosis and because of costs of regular blood tests during treatment to monitor this risk (National Institute of Mental Health, 2010). Clozapine is not prescribed for trivial indications and suggests that Yulia’s psychiatrists considered several different treatment regimens to try to manage her symptoms. Some of the side effects of typical antipsychotics include rigidity, muscle spasms, tremors, and restlessness (National Institute of Mental Health). This is likely why Yulia was also prescribed an antispasmodic. Yulia’s family has tried to find other treatment options as well. In Tbilisi, Yulia was prescribed a newer antipsychotic, “Cizedone” (generic not found), but the family could not afford the drug, which costs 1 lari per pill or 3 lari a day (this is the equivalent of about US\$1.80). They thus returned to the original prescriptions. Not having enough money was also a problem when Yulia attempted suicide, as their insurance did not cover emergency treatment for this. They were later able to negotiate with the insurance company to receive coverage. Ia describes Yulia’s time in the psychiatric hospital as being both positive and negative. The stay connected Yulia with other individuals with similar conditions. However, she was put on very strong dosages of medication and her condition worsened during the stay.

Ia explains that they live with few financial means and rely on their health insurance, which covers free consultations with doctors. Yulia is often bothered by various somatic symptoms, such as stomachaches or heartaches; her family is not always sure if she is actually ill or is inventing problems. Because of this, however, they have called for an ambulance a couple of times, and they frequently visit a general practitioner. Yulia is calmed down by listening to the radio, which she enjoys and uses on her own to soothe herself.

Household and Social Support

Yulia's illness takes a toll on her family; Yulia lives with her mother, father, Ia, grandmother, and another sister. Ia explains that their household income is very limited, but they must spend money on Yulia's medications and food. Sometimes other family members go hungry because they do not have enough. Yulia's mother quit working to take care of her. Yulia receives additional government assistance because of her illness. Ia sometimes feels depressed as a result of her sister's aggression. She describes buying books for her degree program and having Yulia tear them up and deface them: "life almost becomes senseless; you don't know what you work for, what you strive for." However, Ia does not believe that remaining depressed will lead to a good outcome and thinks one should stay strong and face one's problems. Ia explains that: "It might be unbelievable but for us every day is a hell." There is uncertainty about how each day will unfold because of Yulia's unpredictable behavior. Ia explains that her sister's illness, however, has united her family because they share in this struggle. For Ia, family influences a person's mood, and a person cannot be happy if the whole family is not doing well either.

It is difficult for Ia to access support from others because “everyone is surrounded with his/her own problems. Everyone has so many problems that we don’t have time for each other and of course, the financial condition is decisive and the status of refugee is exhausting.” It is also difficult for the family to support other relatives because they are busy taking care of Yulia: “It’s very hard...it affects all the family members’ moods; we try not to show and not to surround others with our problems because we’re having them often.” However, their neighbors are understanding of Yulia’s condition, even though her shouting disturbs them as well. Yulia does not have friends of her own because her communication skills are so limited.

Trajectories

Ia counts the years that Yulia has been ill—twelve at the time of the interview—and struggles to come to terms with this being a chronic condition that is difficult to treat: “I got used to the thought that nothing helps her.” At first her family did not realize that Yulia’s illness was long-term, but they have since understood this. Her family does not have hope that her condition will improve because they see it getting worse. Their hope lies in scientists developing better medications. Ia and her family also place their hope in a higher power. However, Ia’s family struggles with managing Yulia’s illness on a daily basis and worries about how to care for her in the long term: “The disease is so hard that I don’t know, we can’t find a way out.”

Ia finds it difficult to emplace herself within the community and experiences various levels of difference, as an IDP living in a collective center and as a care-giver for a family member with mental illness: “[I]f you want to find a place in society because we’re rejected from life already, and when we watch such illness every day, we still try to

compensate what we are short of and we are very stressed at home and we try to be out in society and compensate for all the things that are missing in our lives, in normal life.” Ia talks about grieving what her family lost and dreaming of the past. She explains that: “[Yulia’s] disease and our distress were very much influenced by the war. . . something still remains in memory, it settles and influences a person’s development.” Distressing memories thus contribute to trajectories of illness. Ia’s view of the future for both her family and Yulia continue to be enmeshed with their experiences during the war.

Narrative 2: Sofu

Background and Problem Description

Sofu is a 35 year old woman living in Zugdidi. After being displaced from Abkhazia at the age of 16, she got married and lived in Zugdidi for a few years, then moved to Russia for 10 years, and returned to Georgia after being deported. This is her fifth year living in Zugdidi since returning, and she lives in a collective center with her parents and child; she is divorced from her husband. She has received support from a local organization, NGO Y, which provides psychosocial services and vocational skills training to IDPs and other vulnerable groups. NGO Y trained her to be a beautician and in the past she worked in this capacity; she is currently out of work and looking for a new salon.

Sofu has experienced several episodes of depression, as she identifies it; she also describes these episodes as being ones where she experienced “problems with nerves.” She explains that when she is experiencing depression, she closes off from others and does not display her symptoms or problems: “If I fall into depression, I’m not in motion,

I become locked in myself. I want to cry all the time, but I can't, I'm somehow reserved, or like nothing is bothering me. I laugh excessively, and I can pretend that I'm in a good mood..." The episode of depression that prompted her to seek help took place around the time of her divorce. Sofio felt "attacked from all sides" with regards to family and financial problems, and as she says, "I found myself in the chasm." Sofio describes feeling alone and afraid; her fears and hopelessness was bothering her to an extreme extent, and she felt that she could not handle her problems on her own, as she usually did. She explains that she was worried about everything, could not work, and had insomnia. During this period, she wanted to leave Zugdidi in order to cut off ties with her ex-husband and his relatives, particularly given his threatening behavior:

Probably it was more than half a year, I don't remember exactly and then I realized that my life was getting worse and worse. I had contact with my ex-husband every day; I listened to threats from him, his relatives—terrible threats. I lived with a tense life on a daily basis, in a terrible rhythm of life. This was probably the main cause of my severe depression and sorrowful condition. Everything affected me; I reached that condition slowly. Then I realized that I needed some help.

Sofio also explains that her well-being during this period was negatively affected by living with her large family, as she could not get along with everybody and was overwhelmed by their presence.

Thresholds

Sofio identifies economic problems as being a primary cause of depression in those around her. However she believes that she experiences more depression than her family. It took time for her to be able to recognize her problem: "Depression is terrible. Earlier I couldn't realize what depression was. Now I just understand what it is. I have fallen into this depression so many times..." She realized she needed to seek professional care when

she felt she could not solve her problems on her own. At this point she understood that if she did not get care and change her life, she would be devastated. She therefore sought out advice from a close friend. For Sofo, hopelessness is also a marker for recognizing depression; she currently feels that she is back in a depressive state because she is feeling hopeless again. Another marker is worry and fear; while experiencing depression, she realized that she was feeling similar to how she felt after her brother committed suicide, years before, and this helped her understand that something was not right with her.

When Sofo describes the counseling treatment she received, she explains that she was “ready to talk to somebody about my problems,” which facilitated her seeking care and engaging in therapy. There is a sense that Sofo accepted her condition and that she needed help: “I couldn’t keep living like that and I had to do something; I had to take some steps to change things to be better.” For Sofo, it is normal for anyone to get help from a psychologist. Similarly, if people have problems, they can also access support from a priest. Sofo believes that disclosure about problems should not invoke shame: “If you tell a priest about any disease, at that time you need support...there’s nothing to hide. On the contrary, you should talk.” Indeed, once recognition and understanding of one’s psychological problems takes place, Sofo believes that one has a responsibility to seek care. However, she also expresses an understanding that mental illness is not something a person can be responsible for addressing without understanding it: “Until you realize this [that one is unhealthy and needs help], there’s nothing to be ashamed by...this is a disease too...But when a person recovers from the situation and thinks about his behavior, that’s when he should realize that he needs help so that the same

thing doesn't happen to him for the second time." Although Sofo emphasizes the importance of self-care and the responsibility that comes with recognition of illness, she also suggests that the burden of illness should not be borne by individuals alone. People need support in understanding and managing mental illness. She later suggests holding trainings to inform people about psychological problems and options for care, something that she did not have. Sofo is thus coming to terms with her own delays in recognition and management of her condition.

Timing and Turning Points

Although Sofo has experienced several episodes of depression, the episode that led her to seek help from a psychologist occurred a year before the time of the interview. This episode was a key turning point for Sofo, as it took place around the time of her divorce. Her intense feelings of worry, fear, and hopelessness spurred her to seek professional mental health care for the first time. It took Sofo about half a year to recognize that she had a problem that needed care: "From the beginning, I didn't even realize it. For about half a year I seemed to be good and I didn't understand that I was getting closer and closer to the chasm from which I wouldn't be able to get out."

Treatments

When Sofo is feeling depressed, she first tries to solve her problem on her own using self-care strategies such as positive thinking: "Sometimes I work on myself and I recover somehow. I tell myself that everything will be okay, it won't always be like this...Sometimes there are radical situations when I fall into depressions, but at the end I manage to recover. Most of the time I work with myself on my own." Self-care thus

also involves feeling hopeful about the future. Sofo next turned to a close female friend who told her about NGO Y. At that time Sofo did not have anyone else to talk to. Sofo was not aware of this NGO's services or any other community mental health services in the city: "At that time, I found one female friend, who showed me the way out. She told me that there was a person who could help me and that she would take me there. . . this girl told me that such an organization exists."

Sofo then met with a psychologist at NGO Y who helped her recover. She began counseling treatment with this psychologist immediately. Sofo did not know what to expect: "I didn't have an idea because I was there for the first time. I had only seen it from the movies. . . I don't know, for me it was very strange and interesting at the same time." When Sofo explained to her psychologist that she was experiencing "problems with nerves," she was referred to a neuropathologist (a type of neurologist) and together they provided her with a seven day course of care in a private inpatient facility. She was at the facility on her own and received care from both her psychologist and the neuropathologist. Treatment involved taking several different kinds of medications, which Sofo cannot remember. After this treatment, Sofo continued receiving outpatient care from the neuropathologist on several occasions and was prescribed different medications for several weeks. Sofo does not reveal more about the private facility where she received this treatment, except to say that it was privately funded, rather than state run, and that it was housed in an apartment complex: "They asked me not to tell anybody back then, it was supposed to be kept as a secrete. This was a private institution...the NGO has rented this private apartment and officially it's for people who

need help.” It remains unclear what this facility was or why it could not be talked about, except perhaps, to protect patients’ anonymity.

Sofo has found support in other forms, as well. Going to church calms her down and is helpful during periods of trouble. She has also tried herbal folk remedies such as drinking mint tea, water with honey, and honey and milk: “[F]olk medicine really helps me. Or maybe I believe and I have faith and that’s why it works... I think it really works.” Herbal remedies help her to manage her stress and recurring periods of depression: “I feel much better now, sleeplessness bothers me much less at night and if I feel something, I prepare it and I drink it and it helps me and calms me down a lot.” Sofo is now able to self-manage and feels a sense of control over her condition; this, combined with the symbolic efficacy ascribed to these herbal remedies—as Sofo says, “I don’t know whether it’s the faith, but it really helps me”—contributes to her decision to use these approaches. However, Sofo feels that traditional approaches like *mokhvetse* undermine recovery efforts because they emphasize control and restrictions, whereas psychological recovery requires becoming free from struggles.

Household and Social Support

Sofo explains that she feels out of place and does not feel like a member of the local community: “I wouldn’t say so; it still can be said that you’re a stranger. You are among Georgians and you’re a stranger. . . I couldn’t realize that there can be another place for me besides Abkhazia.” She seeks out help from her family for financial problems, although they are not able to help her because of their limited resources. She is not comfortable talking to them about her personal difficulties. One of the reasons why she does not seek support from her parents is because they do not help her find strength in

herself or hope in the future in the way that her psychologist does. Sofu has just one best friend with whom she feels comfortable sharing and who has supported her throughout difficult periods of her life; she sees her every day but otherwise does not have a lot of friends. When they meet they often talk about life and why it is so difficult. Accessing support for Sofu involves commiserating over life's problems.

In general, Sofu feels that talking about one's problems is useful for feeling better but also feels she should take care of her problems on her own: "I can open up to and say everything only to her [best friend]. I feel more freedom at that moment, but those problems remain as problems." Sharing is difficult for Sofu, but feelings of loneliness prompt her to want to share with someone. Yet, Sofu lives in a large family within a collective center and thus has many people around her. However, she feels stifled by this environment and wants space for herself. Sofu feels that being constantly surrounded by other IDPs and being enmeshed, together, in each other's lives, prevents recognition of individual problems and realization of one's life:

[W]ith refugees, there's a problem that large families live together. This is also a problem and there is a moment that people get on each other's nerves in life, they don't understand each other because they don't have the comfort to live separately, on their own and as they want to. You can't live as you want and you have to live like others want you to; and they can't manage to separate these people, and give them separate places to live in;

In Sofu's family, her father typically makes major decisions for the household, while decisions about health care are made collectively. Sofu chose not to involve her parents or immediate family in her decision-making about seeking mental health care. After a few months in therapy, she disclosed her diagnosis and treatment seeking with her family, who were accepting of it and expressed trust in her psychologist. She

explains that she chose not to involve her family because she needed to get help on her own. Since Sofu emphasizes the importance of trying to solve problems independently, it appears that choosing not to involve others in her decision-making allows her to position seeking professional care as an extension of self-care. Sofu chose to augment her self-care with professional services but is still able to claim and have agency over this choice. As she further explains, professional help is not successful unless the individual is ready and also does work on herself: “Again only working on myself psychologically [helped]. Of course a psychologist, a friend, but most of all if I don’t overcome myself, nothing will work out.”

Trajectories

Sofu understands her depression to be both chronic and discrete; she has recovered from multiple bouts of depression, but she also refers to her struggles as a “condition” that comes and goes: “Now it seems that I’m back to it again.” For Sofu, recovery is a repeated but discrete process that occurs after each episode of depression. Recovery also requires ongoing monitoring of symptoms. Sofu has now established a regular relationship with her psychologist at NGO Y and continues to see her on occasion: “For psychological help, I address my psychologist. If I have a very, very hard time and I can’t overcome it, then I go to my psychologist.” Continued care is accessible, but Sofu only chooses to access it if she is not able to solve her problems on her own. Overall, Sofu feels “much better” than she did before she accessed psychological care, suggesting that she is experiencing a positive trajectory of management.

Narrative 3: Lasha

Background and Problem Description

Lasha is 21 years old and living in Poti, a small port city south of Zugdidi. Living in Poti is like living in “one big village,” because there is not much to do. Lasha lives with his family in a new private apartment complex on the outskirts of Poti built specifically to resettle IDPs; his family moved into the complex two weeks before the interview took place. Before ending up in this apartment complex, Lasha and his family lived in a number of other locations. Lasha explains, “We lived in horrible conditions for 18 years, in the conditions where there was nothing.” Lasha’s family was displaced from Abkhazia when he was three years old. They first arrived in the southern port city of Batumi by ship. They lived in a boarding house for some time and then, Lasha explains, “we found ourselves in Poti because they said they were giving shelter to people in Poti in governmental institutions.” There, they lived in a hotel for a week, then rented a room in a Russian person’s home for some time. Eventually they were given rooms in a collective center in the city. Now, although he has to pay 1 lari a day for transportation into the city center for work, he feels that it is worth it because living conditions are much better. Lasha lives with his parents and grandmother; his two brothers, both married, live in an adjacent apartment which connects to his. His sister and her family are also staying with them temporarily.

Lasha works in Poti as a computer teacher for youth at a center for civil development and integration founded by NGO Y. Lasha aspires to become a psychologist, although he has not yet finished his university degree. When he was 12 or 13 years old, Lasha experienced an incident of prejudice in his school. An older teacher

of his was denigrating IDPs in Poti and accusing them of taking everything from local residents. Lasha reacted by throwing a chair at her in anger. Most of his classmates were from IDP families and stood by him. This resulted in the teacher quitting her job. Lasha describes other examples of resentment from local residents because of services they received from the government. He explains that he used to become nervous as a result of such tensions but does not any longer. His best friends are non-IDPs, and he does not feel that perceptions of difference exist among the younger generation. Lasha does not want to feel different but he also talks about how the government forgot about long-term IDPs after the 2008 war; he thus still desires recognition of his status.

Lasha explains that he rarely feels depressed and is less depressed than his family members or others around him: “[N]ow if we walk by, every second person is depressed.” However, he feels that family problems most often cause depression. His problems center on interpersonal struggles with his father and brothers. Lasha explains that he is not close to his father, whom he considers selfish. Lasha often gets into fights with his father, particularly when his father comes home drunk: “I’m sometimes reaching the condition when I want to kick him out of the house when he’s drunk...when you drink to the stage that you can’t come to your house on your own, no, no, that’s too much. We argue about that often. He then must stay at the place where he drank.” Lasha’s father has also been physically abusive and used to hit Lasha, as well as his mother:

Now I won’t let anybody do it, there’s no way, but when I was a child, I witnessed this. This is sitting in my head; now I can’t even imagine how my father hit my mother. At first he hit me, and then he hit his wife; it’s that he hit my mother, not his wife. After that I drew a line for my father, well, he’s a father and I respect him and somewhere, deep in my heart, I might love him, but anyway, I’m like this. Sometimes I might pass him, and not even say hi.

Lasha explains that this was very difficult to experience not just because of the abuse or witnessing how his mother was treated, but because he needed a father to take care of him. He also has conflicts with his two older brothers, the younger of whom has a lot of debts and is constantly asking for money from his mother, something that bothers Lasha. His eldest brother spent some time in prison earlier because he did not adjust well to the changes his family went through while displaced. Lasha attributes feelings of depression to this: “If I ever had depression it was because of him.”

Thresholds

Lasha first noticed that something was wrong in his relationship with his father when he was a child and his father would hit him. When Lasha is struggling with a problem, he notices that his mood changes and that he wants to be alone: “If I want to be alone, that means that I’m feeling bad and I don’t want to see anybody at that time.” Lasha believes that there is nothing wrong with having a psychological problem; all diseases require treatment, including mental ones. Lasha feels that “diseases concerning nerves” are in fact more serious than other diseases “because nervousness takes away from you the spirit, spiritual health...spiritual health is more important and it’s important to have the nerves in order.”

When Lasha told his friends that he was speaking with a psychologist, they had mixed reactions. Some thought it was a good idea and were interested in getting care themselves. Others felt differently: “There were a lot who said that I was crazy and that’s why I talked to a psychologist.” However, those who felt positively noticed that he was calmer. Lasha’s mother was happy that he was helping himself. Lasha explains that his

attitudes shifted after working with a psychologist and he realized that analyzing and talking about problems can be useful.

Timing and Turning Points

Lasha has been receiving care from his psychologist at NGO Y for two years. In general, when he does seek out help, he does so immediately after experiencing an interpersonal problem. If too much time passes, he will not share it because he does not like to dwell on issues. Lasha does not mention a key moment that prompted him to seek care, but becoming involved with a computer training program run by NGO Y was a turning point for learning about and being able to access psychological support.

Treatments

Lasha keeps his feelings hidden and tries not to show them to anybody: “I’m always in the same condition, nothing is expressed on me, I just feel it inside of me, that something bothers me.” Lasha explains that he tries to solve his problems on his own. Sometimes he goes down to the seaside because it calms him down. If being alone does not help, then he turns to his close friends. He explains that he has carefully selected friends who are “competent,” whom he trusts, and who are good listeners: “I have chosen the people who have developed some psychological skills.” However his friends are very busy so he cannot always turn to them; still, he knows that they are available if he has a very serious problem. Lasha thus actively manages his social support system. Lasha expresses mixed feelings about the potential for religion to help people with psychological problems. He explains that he engages with religious rituals but is critical of the Orthodox Church and its dogmatism. He used to share his problems with his

priest but no longer does. On the other hand, he also believes that religion, or perhaps faith, can help solve a person's problems: "It helps me in everything. Well, when I stand in front of the icon and talk, then I don't need a psychologist at all." Lasha thus differentiates between the institution of the church and the potential of personal faith.

Lasha met his psychologist at a job training at NGO Y and they became friends. Later, when he had problems he would contact her and speak with her in her role as a psychologist. When he speaks with her, he feels much better and is helped. He explains that talking to his close friends and to his psychologist is like having a mirror held up to him and his problems. He believes sharing problems and "psychological interventions" are important for overcoming psychological struggles. His psychologist helps him understand conflicts he is experiencing, provides him with inter-personal communication strategies, and helps him get through relationship problems with family and friends. When he speaks with her, he explains that she has a calm and warm approach, which in itself is helpful:

She never hurries me up; we always talk in a very calm environment...she talks from her heart and her conversation is very warm; such energy is coming from her, that it's enough for me. She might not be telling me some special words but it's enough for me whatever she tells me.

Lasha still calls his psychologist at times but tries not to bother her unless he has a specific problem. He has only talked in-depth about his troubles with his father to his psychologist and to one other friend of his.

Household and Social Support

Although Lasha feels close with most of his family, it is his mother with whom he has the closest relationship and feels he can talk to about anything. Otherwise, he does not share

his problems with his family members. Lasha has four close male friends, or “brother men,” [ძმაცაცებო/ dzmakats’ebi] to whom he can open up and share problems. His friends also come to him for advice and support, including financial support because they are often in debt. Other times, they simply talk. Lasha is sometimes concerned that he is “surrounding others with [his] problems,” but he realizes that his friends want to help him.

Trajectories

Lasha has become used to his father’s behavior and is able to manage his frustrations with him more effectively; he explains that he does not pay much attention to it and only demands that his father not come home drunk. Lasha maintains a relationship with his psychologist and knows she is there for support if he needs it: “She helps me wonderfully, so if something bothers me, I only tell her about it.” Lasha is fairly open with his friends about receiving psychological care. It appears that he has integrated this kind of support into his understanding of what is normal and his other management strategies. He is interested in studying psychology, pays close attention to his emotional support network, and believes everyone who needs help should be able to access mental health services. However, he believes that services need to be normalized so that people do not feel like they are being “treated,” but rather, feel they have a place to go to for support.

Reaching Recovery: Treating and Managing Mental Illness and Psychosocial Problems

Thresholds, Timing, and Turning Points

These three narratives suggest that thresholds in seeking care include thresholds for recognition of illnesses and decision-making about care, as well as thresholds for disclosure of problems. Significant delays in recognition—and formal treatment seeking—are common for individuals with mental illness (Wang et al., 2005). Each of the individuals experienced delays between onset of problems, recognizing problems, and accessing services. The three narratives make clear that the recognition process necessarily involves individuals' perceptions of causes of symptoms and illness. For example, Ia explains that her family initially considered Yulia's behavior to be a teenager's reaction to the difficult experience of war and displacement. Even now, they continue to identify the war as the cause of her illness, rather than perhaps a trigger. The recognition process is shaped by the processing of external events, such as the abuse Lasha experienced, as well as internalized states, such as the hopelessness that Sofio describes. Pescosolido's (2006) NEM-II acknowledges that social context and social networks actively shape problem recognition and decisions about care strategies, as well as the actual provision of informal advice and services.

The points at which individuals decide to disclose their illness or the fact that they have a problem and need help emerged as a second aspect of thresholds in care-seeking. Thresholds for disclosure thus also reflect levels of readiness to seek and receive help, as well as levels of acceptance of psychological problems. None of the three

individuals viewed mental illness or psychological problems as something to be ashamed of and for the most part, did not experience stigmatizing reactions from friends and family when they disclosed their conditions and treatment.

Formal Services, Lay Care, and Social Support

Ia, Sofo, and Lasha described using a range of approaches within the informal, lay, and formal sectors. These approaches are broadly categorized and listed in Table 5.1.

Approaches, or strategies, can be considered as falling within four domains: Self-Care, Household, Community and Lay Support, and Formal Services (See Table 5.2). For examples, folk remedies fall within the community and lay support domain because they draw on shared knowledge and cultural systems. Similarly, while religious rituals such as praying before an icon are individual behaviors, they are practices prescribed by the social institution of the church and thus fall within the community domain. In the context of the collective center, the 'household' cannot be understood solely in terms of the physical boundaries of living spaces. Instead, the household might be understood to be the most proximal social network for individuals, comprising family members and close friends, both within the center and elsewhere, as well as neighbors within the center.

Individuals moved across these four domains in a non-linear, cyclical fashion. This is illustrated in Figure 5.1. The three narratives demonstrate that individuals and families often begin with self-care and an attempt to solve problems independently or with household and social support. The three interviews were selected, in part, because they also represented care-seeking within the lay and formal sectors. However, earlier

reviews of interviews across the sample of 39 IDPs demonstrated that individuals mostly accessed care within the self-care and household domains, which are shaded in bold in Figure 5.1. At times individuals ventured into the community and lay or formal service sectors, shaded in light colors in Figure 5.1, but this was not a linear trajectory with a clear end-point at service utilization. Instead, individuals cycled back into independent management of problems and access of support from social networks. That is, individuals mostly managed their illnesses and problems on their own and sought informal care, but when crises or turning points occurred, they temporarily moved out of these domains to seek formal services. These results conform to the NEM-II, which presents care-seeking and management processes as dynamic and cyclical.

The NEM-II considers the treatment system to be both a provider of services and a key influencer of behavior and management patterns. For example, Ia explains that her family first tried helping Yulia on their own with herbal folk remedies but then decided to move into the formal services domain. However, Yulia's family also turned back to the community and lay support domain to try *mokhvetse* when Yulia's medications were not as effective as her family had hoped. Now, Yulia's family moves between the household and formal services domains by managing her drug regimen on their own, while continuing to access support and medication from her psychiatrist, as well as medical care to address her physical complaints. Yulia is also sometimes able to engage with the self-care domain when she plays the radio or reads on her own. Movement across domains and care-seeking is therefore cyclical and always shifting.

Illness and Recovery Trajectories

Both recovery “in” and recovery “from” (Davidson & Roe, 2007) trajectories were present in these narratives. Recovery “in” refers to the ongoing management of chronic mental illness, as is the case with Yulia and her family. Ultimately, Yulia’s recovery is limited given her family’s money shortages, her poor reactions to her medications, and the fact that she does not seem to have access to any kind of psychosocial intervention. Recovery “from” refers to the resolution of discrete illness episodes, even if they occur within a chronic illness context. Thus, both Sofu and Lasha display recovery “from” and recovery “in” trajectories; they describe resolving separate episodes of depression or interpersonal struggles but also explain that they continue to monitor their mental health. Lasha seems to be the most resilient of the three, perhaps given his young age and the fact that he did not experience the war as directly. Sofu worries that she might be slipping back into depression and struggles with finding her own place and path, particularly while living among other displaced persons. Both, however, are able to recognize and manage their problems and have continued access to trusted professional care.

Readiness and Choice in Seeking Care

These narratives illustrate that recognition, and even acceptance, of illness may not be enough to prompt individuals to seek help, particularly professional mental health care. Readiness for treatment and acceptance that external support is necessary for recovery is a key facilitator of care-seeking. Sofu describes being ready to talk to somebody because she could not longer cope with the way she was feeling and needed to take steps

to change her life. Readiness also has to do with a family's ability and willingness to care for an ill family member, as illustrated by Ia's dedication to her sister's health.

Readiness or motivation to get help in part suggests perceptions of autonomy over healthcare decision-making and positions seeking professional care as an extension of self-care. Both Sofo and Lasha emphasize the importance of self-care and management in their recovery trajectories but also recognize that they have the ability to seek help from professional providers. Anderson, Blue and Lau (1991) note that the self-care movement is based on the notion that self-care is empowering as it emphasizes choice and control. However, they argue that ultimately, an emphasis on self-care is not (only) about individual empowerment, but is driven by a consumer approach to recovery: "Self-care is not an isolated ideology, but mirrors the ideology of individualism in the capitalist state; individual responsibility for self and individual ability to chart the course of ones' [sic] life underpin this movement" (p. 102). Further, Anderson et al. contend that studying illness management patterns must account for sociopolitical, cultural, and economic contexts.

In the context of Georgia, this emerging recognition of the role of self-care may reflect the ongoing shift in health systems from a state-centered, public, and paternalistic approach to a de-centered, privatized, and consumer oriented one. IDPs must navigate this evolving service space within the context of a highly centralized formal mental health care system and their state prescribed status of "IDP" and accompanying government health insurance. For example, Yulia's family listened to what Yulia's primary psychiatrist suggested in terms of medications but also actively sought out opinions from other providers; eventually, they returned to the original drug

regimen covered by government insurance and dispensed by a state-run dispensary. Ia acknowledges the authority of the primary psychiatrist but also understands that her family has access to choice of services and treatments, and they are willing to exercise this choice. What ultimately constrains Yulia's family in seeking the best care for their daughter is not the proscriptions of providers, but the lack of availability of diverse therapies and their inability to pay for different medications; this is one of the negative consequences of a newly privatized drug market in Georgia (Gotsadze, Bennett, Ranson, & Gzirishvili, 2005). Individual autonomy over care-seeking is shaped by other structural factors as well, including cost of services beyond initial consultations, as well as knowledge of mental health services. Other barriers to seeking care include recognition of problems and concerns about overtaxing support systems; Lasha even worries about burdening his psychologist with his problems.

Displacement and Community Connectedness

These narratives focused on experiences of illness and treatment but are enmeshed in a broader context of displacement, social integration, and community. Experiences of war, displacement, and struggles such as discrimination, housing insecurity, money shortages, and war-related distress permeated individuals' illness experiences. Further, for Sofu and Lasha, professional care was accessed through an organization whose primary beneficiary population is IDPs. Achieving social integration for IDPs must involve knowledge of mental health services in the community.

Participants recognized that war and displacement has an impact on psychological health. Ia explains that IDPs want to be able to work but are stuck at

home, and this inactivity leads to depression. Sofu struggles with living in a collective center and being surrounded by others' problems. For Sofu, recovery from psychosocial problems, and perhaps from displacement as well, requires having one's own space. Thus, the collective center is not necessarily a protective space if it does not allow for accessing support. Several themes arose from this analysis that link in with findings presented in Chapter 4. They include the non-linear process of ending up in the collective center as well as the dynamic and ongoing process of struggling through illness and displacement. Being out of place and wanting to emplace the self, as well as disclosing illness, were also key processes. Not wanting to burden others with problems and keeping problems to oneself was important. The narratives also illustrate the importance of warmth and feeling a sense of hope in interactions with family and professional care-givers.

Building a Community Mental Health Care System

In both this analysis and the analysis presented in Chapter 4, talking, sharing, and telling one's story are considered helpful modes of accessing social and emotional support and ultimately, are linked with recovery processes. On the other hand, IDPs in both analyses also emphasized keeping problems to themselves, stoicism, and not wanting to spread distress or burden others in their care networks. Despite this tension between internalizing or independently managing one's problems and opening up to social support, participants expressed the therapeutic potential of talking. Lasha, for example, believes that it would be useful if there were more psychological services available. He suggests that people need to feel comfortable accessing care without

feeling like they are being treated for a problem or being cured from a disease. He explains that services that center on talking about problems might be a useful approach, but the public may need to attend trainings to learn about problems and therapy in order to be able to ask for help. Sofo had positive experiences with her therapy and feels that care from psychologists and neuropathologists should be made more available to people. Like Lasha, she believes that the general public needs to be educated about psychological problems and where to go to access services:

In my opinion, it would be good to hold some trainings and inform people more about psychological problems in general. It's because, as I told you, I didn't even know what was happening to me, or what I needed. A lot of people don't know how to behave, who to ask for help, how to help themselves and with these trainings people would get more information, realize better what they feel, what kind of help they need, how to give a hand to others...

Ia expressed gratitude for the interview and the interest of the study team in her sister's condition. She suggests that inpatient hospitals be built in every region. She also suggests creating small groups where individuals with serious mental illnesses like her sister could socialize, share their problems with each other, and participate in activities. She explains that these individuals have skills too and it is her wish to "make life beautiful for them because their life really has lost the meaning; nothing exists for them."

Conclusion

This analysis has demonstrated the complexity and dynamism of care-seeking and recovery trajectories within three narratives. Further, it suggests that processes of displacement and mental illness intersect at various points, including recognition and

perceived causes of illness, stressors such as discrimination, affordability of care, available services such as psychosocial programs for IDPs, and the support potential of informal networks. Informal support systems are particularly important in the context of long-term Georgian IDPs, given the current underdevelopment of the community mental health care system and limited formal services. Further, IDPs' experiences of protracted displacement and uncertain prospects for integration within the wider community underscore the importance of the immediate social network and household in recovery. Interventions should focus on supporting informal care-givers, identifying intervention points within care-seeking trajectories, and building lay referral networks to facilitate the transition from informal to formal care, when needed.

Tables and Figures

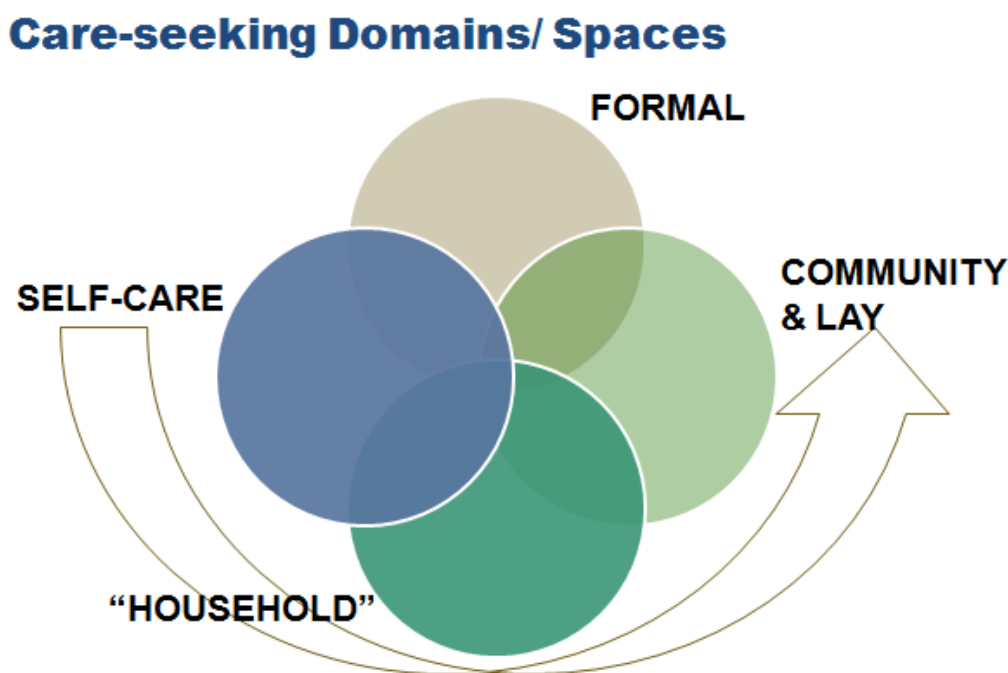
Table 5.1. Summary of Three Narratives

No.	Pseudo-nym	Sex	Age	Residence Type	Type of Illness Episode Discussed	Care Strategies Utilized
31	Yulia/ Ia (proxy)	F/ F	26/ 22	Collective Center, Zugdidi	Schizophrenia	<ol style="list-style-type: none"> 1. Consultations with psychiatrist 2. Outpatient drug therapy with psychiatrist 3. Inpatient psychiatric care 4. General practitioner 5. Emergency medical services 6. Psychologist 7. Mokhvetse 8. Folk herbal remedies 9. Informal care-giving from family 10. Self-care
36	Sofo	F	35	Collective Center, Zugdidi	Depression, Problems with Nerves	<ol style="list-style-type: none"> 1. Psychologist 2. Neurologist/ Neuropathologist 3. Drug therapy (inpatient and outpatient) 4. Social support from friends 5. Folk herbal remedies 6. Church 7. Self-care
38	Lasha	M	22	New Apartment Complex, Poti	Interpersonal Problems	<ol style="list-style-type: none"> 1. Psychologist 2. Social support from friends 3. Self-care

Table 5.2. Care-Seeking Domains and Practices

Self-Care	“Household”	Community and Lay	Formal
<ul style="list-style-type: none"> • Keeping problems to oneself/ “Locking in”/ Stoicism • Masking problems/ Putting on a happy face • Positive thinking • Listening to the radio • Going to the seaside • Managing social support system • Recognizing problems 	<ul style="list-style-type: none"> • Informal care-giving from family • Social and emotional support from family • Social and emotional support from friends • Social support from neighbors 	<ul style="list-style-type: none"> • Advice and support from priests • Religious prayers and rituals • Folk traditions, e.g. Mokhvetse • Folk herbal remedies 	<ul style="list-style-type: none"> • General Practitioner • Emergency medical services • Psychologist • Psychosocial/ Vocational training • Psychiatrist • Inpatient psychiatric care and drug therapy • Outpatient psychiatric care and drug therapy • Neurologist/ Neuropathologist

Figure 5.1. Care-Seeking Domains and Spaces



Chapter 6. Discussion of Findings, Implications, and Next Steps

Overview

This dissertation has investigated and presented different aspects of living with displacement and mental illness, as well as seeking integration and recovery among the internally displaced population in Georgia. It has done so by considering experiences of problems, functioning, and care-seeking at individual, household and community levels. Chapter 3 examines community wide problems, local forms of functioning, and terminology used to describe mental illness within a sample of older adult IDPs across three sites in Georgia. The sample includes both long-term and recent cohorts of IDPs, as well as individuals living within a range of settlement types. The aim of Chapter 3 is to examine key community-wide problems, including experiences of mental illness and functioning, across this sample. The analysis considers functioning in terms of individual level care, household level support, and community level participation and also examines key informant perspectives. Chapter 3 thus provides a community-level perspective of displacement-related, economic, health, and mental health problems among Georgian IDPs. Chapter 4 contributes a household and collective center perspective of social networks, social support, and social cohesion. This study considers the process of becoming socially integrated as a kind of recovery from long-term displacement. It examines how long-term IDPs understand their lives in displacement, negotiate emotional and social support seeking within the collective center

environment, and grapple with what they have lost. It also examines evolving perceptions of belonging, and aspirations for the future. Chapter 4 therefore examines the impact of displacement on IDPs' inner and collective psyches, as well as how identity, notions of home, and integration contribute to support seeking and well-being. Chapter 5 provides a more micro or individual level examination of narratives of mental illness care-seeking. It takes a targeted look at experiences of mental illness and psychosocial problems in the Georgian context by examining three narratives of living with schizophrenia, managing depression and nervousness, and dealing with interpersonal struggles. The analysis examines these experiences through different dimensions of care-seeking. In the process, it also considers how the broader context of displacement intersects with and affects care-seeking and recovery trajectories.

Summary of Findings

These three chapters provide distinct, yet linked, examinations of mental health and displacement. This section examines commonalities and particularities across the three studies. The three analyses demonstrate that there is some common terminology for thinking about and describing mental illnesses and symptoms, for example, depression, nervousness, and problems with nerves. Participants across studies also talked about common experiences linked to both displacement and social support seeking, including experiencing passivity and demoralization because of chronic displacement, feeling forgotten about and isolated from the broader community, feeling out of place, and worrying about being a burden to friends and family. The studies also demonstrate common barriers to health care access, including the limited health insurance available

to IDPs for specialist care and prescription medications, physical and social isolation, and not knowing about available community mental health services. IDPs across the three studies also emphasized the importance of fulfilling family responsibilities and care-giving for their own well-being and functioning and the effectiveness of sharing and talking about psychological problems. In addition, participants described the mix of support and tension that often exists in the collective center or settlement environment.

These analyses also reveal different themes and experiences specific to each sample. IDP participants from Chapter 3 were all older adults and thus presented issues often associated with this stage in life such as chronic physical illness, being inactive due to retirement, and feeling unable to contribute to the community. The sample from this study represented a wide range of regions, housing types, and years in displacement, therefore providing information on differences in experiences across regions. For example, IDPs in Tbilisi more frequently mentioned feeling disconnected and isolated than did those in Zugdidi. This study also examined the particularities of experiencing displacement, including associated vulnerabilities and resiliencies, for older IDPs. Participants' narratives from Chapter 4 sheds light on these IDPs' conceptualized aspects of social integration and cohesion, such as belonging and trust, and provides information on different dimensions of these processes. This study presents in-depth examinations of these processes in two sites, Zugdidi and Tbilisi, and thus allows for comparisons to be drawn. Results conform to findings from Chapter 1 and suggest that the process of becoming integrated and experiencing belonging is more difficult in Tbilisi. This is perhaps due to cultural and linguistic differences between the two regions, the proximity of Zugdidi to the Georgia-Abkhazia border, as well as to the

shared experiences of war among both IDPs and non-displaced residents of Zugdidi. Narratives from Chapter 5 focus not on social integration but on episodes of mental illness and treatment seeking. However, the analysis parallels problems described in Chapter 3 and the difficulties of life in the collective center described in Chapter 4. Participants in both Chapters 4 and 5 described the intricacies of accessing their social networks for emotional and social support.

Strengths and Limitations

There are not many studies that have examined mental health in Georgia and/or with Georgian IDPs. To the best of this author's knowledge, this is the first study to examine care-seeking for mental health problems among IDPs in Georgia. This research is unique in its investigation of the process of social integration and social support seeking among displaced persons from a public mental health perspective. Study 1 is also unique because, to the author's knowledge, it is part of the first investigation of older adult IDPs' mental health status in Georgia.

The qualitative research design employed in this research allowed for an in-depth and rich exploration of behaviors, social processes, ecologies of recovery, and context. This research was unique in its application of a range of theoretical perspectives, from Braidotti's (2011) critical framework of nomadic theory, to mental health care-seeking and recovery models, to models of local integration of displaced persons. The three studies that this research comprises utilized various qualitative methods of data collection and analysis, including free-listing, in-depth interviews with IDPs and key informants, site visits, as well as Grounded Theory methods and thematic analysis. In-

depth interviews facilitated the collection of narratives, description of behaviors and processes, and contextual information. Grounded Theory methods provided an iterative approach that allowed for local perspectives and emerging concepts and ideas to be integrated into both data collection and analysis. A range of perspectives were captured from IDPs of varying ages and residence types, as well as from different key informants. Finally, the study team included skilled Georgian interviewers, some of whom were IDPs themselves and spoke Mingrelian.

A key limitation of the study is that data collection methods relied on narrative forms, rather than observations, participatory or systematic methods, or document analysis. Community asset mapping, walk-about, and pile-sorting, for example, would have augmented analyses of social support space, the collective center space, conceptions of mental illness, and care-seeking decision-making. Free-listing may not have allowed for the naming of complex problems or sensitive topics; further, free-listing provides limited conclusions about perceived importance of listed items. Grounded Theory methods and iterative data collection and analysis were limited in the field because of restricted resources, time consuming processes of transcription and translation, and the fact that continued access to, and multiple interviews with, disadvantaged groups like IDPs, is difficult. In addition, while semi-structured interviews were useful given restricted resources, their use necessarily limited what was discussed during interviews, as well as a more inductive entry into the study topics.

Although qualitative inquiry is not concerned with sample size for drawing statistical inferences, the overall sample sizes for Studies 2 and 3 were small, and transferability of findings may be limited. This is particularly true for findings from

Study 2 about IDPs in Tbilisi. On the other hand, these studies produced rich findings on experiences of Georgian IDPs and the processes of social integration and care-seeking in protracted urban displacement contexts. Chain sampling was employed in this research, which can restrict the diversity of experiences and attitudes among participants; however, chain sampling was useful for gathering information on social networks within collective centers and participants' knowledge of community experts (for key informant interviews in Study 1). Another possible limitation is that key informant interviews in Study 1 were not recorded. While recording can change the dynamic of interviews and limit what is said, the author did not find that it comprised the telling of rich narratives in other rounds of data collection; therefore, it is possible that some of the data collected in Study 1 were incomplete. This research relied on assistants, which necessarily impacts the course of interviews and data collected; however, research assistants were carefully trained and supervised, personally motivated and engaged, and became partners in the research endeavor. The author also developed a close collaboration with the primary translator.

Credibility and Transferability

The credibility of findings within these three studies involved debriefing with research staff and assistants on the study protocol, data collection instruments, data collection experiences, staff insight into emerging themes and concepts, and initial interpretations of data. In Study 1, survey data from later phases of the investigation allowed for methodological triangulation. In Study 2, cross-sample comparisons of constructs demonstrated the applicability of key findings to the experiences of other participants.

Study 3 benefited from a process of member checking. Theoretical triangulation was also helpful for interpreting findings from Studies 2 and 3 within different disciplines and conceptual frameworks. Initial results from all three studies were presented to experts and peers to gather feedback, which helped develop and/or verify conclusions. Finally, credibility of findings was strengthened by researcher reflexivity, as well as by varied data and intensive involvement in the study context (Maxwell, 2013).

Findings from this research about mental health problems, changing social roles and identities, experiences with mental health services, and becoming socially integrated are likely to be transferable to other communities of IDPs in Georgia, as well as to other IDP and displaced populations throughout the Caucasus (e.g. in Azerbaijan) and former Soviet Union. In addition, IDPs' experiences with mental health services and associated program implications are relevant to other segments of the general Georgian population. Findings about social networks, support systems, integration, and belonging may also be transferable to other contexts of protracted and internal displacement. Participants' experiences in the collective center and settlement environments are likely to be relevant to other urban displaced populations. Finally, findings may have resonance with the experiences of other marginalized groups living with housing insecurity and poverty in low-resource urban settings.

Theoretical Implications

Living ‘With’ Displacement

This dissertation has relied on interviews with IDPs with regard to experiences of displacement, social support, mental illness, and community. In addition to experiences with social, economic, and psychological struggles, IDP participants for the most part understood their lives as being afflicted by displacement. Individuals structured their lives around displacement and related problems and contended with the personal and relational effects of displacement. I argue that understanding the experience of protracted displacement would benefit from a re-conceptualization of displacement as a chronic condition or affliction. That is, IDPs do not only live ‘in displacement’ but ‘with displacement.’ Like chronic illnesses, living with displacement involves daily struggles with associated problems, shifting identities, management of negative symptoms and consequences, impairments in overall well-being, physical and social isolation, and altered aspirations and personal trajectories. Further, individuals living in displacement face difficulties in accessing appropriate care for what is an ongoing and highly personal experience; in contexts of both chronic displacement and illness, it is the sufferer that is the true expert on the condition.

Rather than solely conceptualize displacement as a factor (e.g. a pre-disposing, contextual, environmental, or demographic factor), I argue that it is more useful for mental health intervention and long-term integration goals to understand displacement as an evolving process or condition, akin to a chronic illness. This condition, like a chronic illness, can be managed and indeed recovered from, but resolution is never

wholly achieved, and the experience necessarily changes the affected individual. Using chronic illness as a theoretical frame allows for a more nuanced understanding of the daily struggles of displacement and consequent effects on the individual and household. The intention of this analogy is not to pathologize displacement or the displaced, nor is it to suggest that medical interventions are required in response to displacement. Indeed, the intention is the opposite: to re-conceptualize and re-imagine displacement as not simply an event or a characteristic of an individual and community but rather as a dynamic experience that must be contended with but that also has the potential for positive outcomes and trajectories.

A view of displacement as ongoing and dynamic allows for ‘recovery’ options. There is no clear delineation of when recovery occurs in chronic illness, as illnesses must continually be managed, even in periods of remission. Rather, recovery might instead be understood as a positive trajectory of management and improvement with fewer and shorter periods of acute illness. Similarly, considering when displacement ends and local integration is achieved for protracted displaced populations cannot be easily measured. However, just as with chronic illness, positive trajectories and outcomes are possible. When displacement is understood to be an event that acts on a person, the subject is made passive and acquires displacement as an immutable part of her demographic profile. Instead, the notion of ‘living with displacement’ re-positions the relationship between subject and experience as recursive and active; despite the experience of inactivity and stasis that often accompanies it, displacement is not a static construct. Applying theoretical frameworks and strategies used in the chronic illness

literature, including viewing the displaced person as an active participant in her own recovery, may be useful for facilitating integration.

Becoming Integrated and Becoming Healthy

If the experience of displacement can be understood in terms of chronic illness, then it is also true that living with displacement and illness intersect in complex and nuanced ways. ‘Becoming Integrated’ and ‘Becoming Healthy’ do not just involve management of conditions and problems, but require a radical reconceptualization of self in light of these conditions. ‘Becoming Integrated’ and ‘Becoming Healthy’ are ultimately transformative, active, and social processes. Integration of displaced persons in host communities is not merely a process of fitting in or adapting. Integration involves fracturing communities from the inside out and transforming them into something new. That is, integration must occur not only for displaced persons but for other community members as well. This means addressing displaced persons’ unique subjectivities, histories, and potentials. The community must speak back to individuals by providing space for integration to occur and engaging with IDPs’ transition. ‘Becoming Healthy’ in response to mental illness is similarly, a dynamic and variously defined process. Mental health cannot only be understood in terms of fitting into and meeting indicators outlined by psychiatric definitions. Conceptualizing mental health is in itself a dynamic process. Recovery processes involve providing space for and allowing in individuals’ voices and varying experiences of illness. This leads to multiple understandings of what it means to be psychologically healthy. A true ‘Becoming Healthy,’ then, affects not just

individuals, but collective interpretations of ill-health and well-being, as well as collective responses to sick individuals.

Therapeutic Landscapes and Therapeutic Citizenship

Analyses in this dissertation have considered ways in which communities in displacement and the shelter space of the collective center support individuals' social and emotional recovery. How do social networks of displaced persons build resilience? What opportunities exist within the collective center for community strengthening and care seeking? These questions invoke notions of therapeutic landscapes and the potential of the collective center (and by extension, the emergency shelter or refugee camp) to be a space for healing. Therapeutic landscapes are those "places, settings, situations, locales, and milieus that encompass both the physical and psychological environments associated with treatment or healing, and the maintenance of health and well-being" (Williams, 1998, p. 1193). Findings from these analyses prompt further investigation into the ways in which informal support structures within the household and lay providers within the community comprise therapeutic landscapes. Applying this framework should also consider how perceptions of emplacement and belonging affect "psychological rootedness" (Williams) and impact recovery. Further, how do aspects of the broader urban environment and formal mental health services sites function as therapeutic landscapes?

Examining recovery and identity transformation within displacement and chronic mental illness also has implications for, and can be informed by, theories of therapeutic citizenship. The notion of therapeutic citizenship suggests that a sense of

identity and community membership, as well as empowerment, may be found in medical encounters and therapies governed by political actions, government structures, and international norms. ‘Citizenship’ involves claiming diagnoses as identity, active illness management, and treatment adherence (Nguyen, 2007). IDPs’ integration and re-claiming of citizenship in Georgia is occurring within a larger unfolding of national identity. At the same time, international norms, aid provision, and interventions that articulate the health and mental health consequences of conflict open up space for an alternative collective identity. Claiming membership within the context of conflict-related traumas and psychosocial recovery may provide a pathway to belonging that is more tenable, and less uncertain, to IDPs.

Implications for Policy and Practice

International guidelines on, and indicators of, local integration should include experiential domains of integration such as connectedness, social support, and belonging. Further, access to health services and service utilization should be paid more attention as indicators of local integration. A comparative analysis of indicators of, and guidelines for, integration that are used by different international organizations and national governments is warranted, as is a comparison of such indicators to theoretical and empirical models of integration. Local integration strategies and policies within the GoG must consider social, economic, civic, and health aspects of integration in addition to durable housing. Further, the GoG should address what kinds of social services need to be in place after IDP specific programs have ended in order to close the gap between displacement and integration. The GoG should continue carrying out durable housing

strategies for IDPs, such as privatization and relocation, but needs to more effectively communicate plans and timelines to IDPs in centers and settlements.

IDP specific services should eventually be subsumed within the broader service landscape. This allows for the provision of clearer pathways to social integration. For example, social and health benefits might be re-designated and dispersed according only to social need and vulnerability, as opposed to having separate mechanisms for IDPs. Pathways to care should be integrated into community-wide mechanisms, not separated as IDP specific services. This is particularly important for long-term IDPs who have essentially become a segment of the country's urban poor population. At the same time, social and health services should account for the unique vulnerabilities and experiences that accompany years in displacement. This transition will be facilitated if government benefits and mental health interventions acknowledge different stages of displacement and associated need. For legal and normative purposes, IDP status is a dichotomous variable. Experientially, however, it is not. Some individuals might need support with problems or symptoms closely related to conflict, particularly in the early stages of displacement; others might need support linked to community participation. Thus, social and health services should not take a one-size-fits-all approach but rather should parallel IDPs' specific needs and length of time in displacement.

Georgia is currently in the process of developing its community mental health system. Program recommendations are for the general population in addition to the IDP population. There are various points along the care-seeking trajectory to intervene in with behavior change programs. First psycho-educational programs and communication campaigns are needed to increase knowledge and awareness of mental illness, available

services, and recognition of symptoms. Interventions that support informal care-givers, who have their own unique experiences with responding to mental illness (Rose, Mallinson, & Walton-Moss, 2002), strengthen social networks (Perese & Wolf, 2005), and build illness management skills would be useful. There does not seem to be any kind of network or social organization across collective centers in Georgia. This might be a useful strategy for building networks and a sense of community. Lay referral networks should also be developed, for example by training religious advisors such as priests to recognize symptoms of mental illness and coordinate with formal providers. There are several NGOs in Georgia that have carried out small-scale projects with priests such as this. Mobile teams of providers who can make visits to collective centers would be useful for overcoming barriers of physical immobility, particularly among the elderly, physical and social isolation, and lack of awareness of services. The GoG should invest in building up cadres of community mental health workers, including ones that train displaced persons. Community care must develop outpatient psychosocial programs for individuals with serious mental illness. Finally, given findings from these analyses about the experienced benefits of talking, IDP specific interventions might create more opportunities and spaces for counseling, talking, and sharing of problems such as that provided by NGO Y.

In addition to the household and network levels, interventions should also work at the community level by considering the community as both an affected population and a provider of care. This might include engaging in confidence-building measures to promote cooperation and reconciliation in the aftermath of conflict, as well as interventions to strengthen community resilience, support community responses to

psychosocial vulnerabilities, and promote social recovery (Silove, Steel, & Psychol, 2006). For example, programs might be developed that create opportunities for IDPs to become more engaged with other IDPs and the wider community. Interventions that facilitate mentorship activities between older adult IDPs and younger IDPs have been demonstrated to improve the well-being of older adults by providing social roles and drawing on experience and skills; such programs also have benefits for youth (Carlson et al., 2008; Glass et al., 2004; Rebok et al., 2004). Programs might also involve training IDPs as community mental health workers and navigators. Opportunities should be developed for IDPs to participate in policy planning and decision-making. Spaces for sharing stories, for example a digital narrative project, could provide those individuals who are interested the ability to share their experiences of displacement and recovery with the broader community. This would contribute to social bridging and community strengthening.

Future Research

Future work directly tied to this dissertation should involve carrying out further analyses of emergent themes and local terms, such as *batonebi* or experiences of anger and aggression. Future work should also involve in-depth analyses of IDP and key informant interviews not included in this dissertation. In addition, a formal dissemination of results to local stakeholders and the participant community should be carried out. Future research should investigate thresholds for recognition and diagnosis, as well as understandings of recovery, from the perspectives of informal care-givers and professional providers. Research should also examine differences in perceptions of

community and belonging among IDPs living in new settlements from the 2008 conflict, as well as those living in private accommodation. Such an investigation might also consider what ‘successful’ integration involves for those IDPs who have moved out of collective centers and into private accommodation. Further work might also examine how different patterns of care-seeking and management map onto typologies of care preferences and management styles. The qualitative data collected for this dissertation could lead to the development of a survey instrument that measures care-seeking preferences.

Future research should address the theoretical development of local integration for displaced persons as a multi-dimensional construct that involves mental health experiences and access to health services. Research is also needed to investigate the construct of integration from the perspective of measurement tool development. This might include developing local integration indicators that assess health services access and utilization among displaced persons, as well as social and psychological experiences of integration. It would also be useful to develop and test psychometric scales that measure dimensions of integration. Finally, formative research for intervention development is needed for projects in community strengthening and mental health.

REFERENCES

1. Ager, A. and Strang, A. (2008). Understanding integration: a conceptual framework. *Journal of Refugee Studies*, (21)2:166-191.
2. Ager, A., Strang, A., and Wessells, M. (2006). Integrating psychosocial issues in humanitarian and development assistance: a response to Williamson and Robinson. *Intervention: International Journal of Mental Health, Psychosocial Work and Counselling in Areas of Armed Conflict*, 4 (1): 29-31.
3. Almedon, A.M. and Summerfield, D. (2004). Mental well-being in settings of 'complex emergency': an overview. *Journal of Biosocial Science*, 36: 381-388.
4. Amnesty International (2011). *Uprooted Again. Forced Evictions of the Internally Displaced Persons in Georgia*. London: Amnesty International Publications.
5. Anderson, J.M., Blue, C., and Lau, A. (1991). Women's perspectives on chronic illness: ethnicity, ideology, and restructuring of life. *Social Science & Medicine*, 33(2): 101-113.
6. Anthony, W. (1993). Recovery from mental illness: the guiding vision of the mental health service system in the 1990s. *Psychosocial Rehabilitation Journal*, 16(4): 11-23.
7. Artazcoz, L., Benach, J., Borrell, C., and Cortes, I. (2004). Unemployment and mental health: understanding the interactions among gender, family roles, and social class. *Research and Practice*, 94(1): 82-88.
8. Badurdeen, F. A. (2010). *Ending internal displacement: The long-term IDPs in Sri Lanka*. Refugee Studies Centre Working Paper Series No. 66. Oxford: University of Oxford.

9. Bakhtin, M. (1984). *Problems of Dostoevsky's Poetics (Theory and History of Literature)*. Minneapolis: University of Minnesota Press.
10. Barg, F.K., Huss-Ashmore, R., Wittink, M.N., Murray, G.G., Bogner, H.R., and Gallo, J.J. (2006). A Mixed-Methods Approach to Understanding Loneliness and Depression in Older Adults. *Journal of Gerontology: Social Sciences*, 61B(6), S329-S339.
11. Bass, J.K., Ryder, R.W., Lammers, M.C., Mukaba, T.N. and Bolton, P.A. (2008). Postpartum Depression in Kinshasa, Democratic Republic of Congo: Validation of a Concept Using a Mixed-Methods Cross-Cultural Approach. *Tropical Medicine and International Health*, 13, 1534-1542.
12. Beiser, M. (1993). After the Door Has Been Opened: The Mental Health of Immigrants and Refugees in Canada. In V. Robinson (Ed.), *The International Refugee Crisis, British and Canadian Responses*. Basingstoke: Palgrave Macmillan.
13. Berkman, L.F., Glass, T., Brissette, I. and Seeman, T.E. (2000). From social integration to health: Durkheim in the new millennium. *Social Science & Medicine*, 51, 843-857.
14. Berman, P., Kendall, C., and Bhattacharyya, K. (1994). The household production of health: integrating social science perspectives on micro-level health determinants. *Social Science and Medicine*, 38(2): 205-215.
15. Biegel, D., Tracy, E., and Corvo, K. (1994). Strengthening social networks: Intervention strategies for mental health case managers. *Health and Social Work*, 19(3), 206-216.

16. Blazer, D.G. (2003). Depression in late life: review and commentary. *Journal of Gerontology*, 58A(3), 249-265.
17. ____ (2000). Psychiatry and the oldest old. *American Journal of Psychiatry*, 157, 1915–1924.
18. Blazer, D.G., Burchett, B., Service, C., George L. (1991). The association of age and depression among the elderly: an epidemiologic exploration. *Journal of Gerontology: Medical Sciences*, 46, M210–M215.
19. Bloom, D.E. and Canning D. (2004). *Global Demographic Change: Dimensions and Economic Significance*. National Bureau of Economic Research Working Paper Series, Working Paper 10817. Available from:
http://www.nber.org/papers/w10817.pdf?new_window=1.
20. Bolton, P. and Tang, A. (2004). Using ethnographic methods in the selection of post-disaster mental health interventions. *Prehospital and Disaster Medicine*, 19(1): 97-101.
21. Braidotti, R. (2011). *Nomadic Theory: The Portable Rosi Braidotti*. New York: Columbia University Press.
22. Brookings Institution (2008). *Protecting Internally Displaced Persons: A Manual for Law and Policymakers*. Washington D.C.: The Brookings Institution – University of Bern Project on Internal Displacement.
23. Brookings Institution and Inter-Agency Standing Committee (2010). *IASC Framework on Durable Solutions for Internally Displaced Persons*. Washington D.C.: The Brookings Institution – University of Bern Project on Internal Displacement.

24. Brun, C. (2008). *Finding a place: Local integration and protracted displacement in Sri Lanka*. Social Science Association of Sri Lanka Publications.
25. Burton, A. and Breen, C. (2002). Older refugees in humanitarian emergencies. *The Lancet, Supplement 360*, s47-s48.
26. Bury, M., Newbould, J., and Taylor, D. (2005). 'A rapid review of the current state of knowledge regarding lay-led self-management of chronic illness: Evidence review.' *National Institute for Health and Clinical Excellence*. National Health Services: UK. Available from: www.publichealth.nice.org.uk.
27. Carlson, M.C., Saczynski, J.S., Rebok, G.W., Seeman, T., Glass, T.A., McGill, S., . . . Fried, L.P. (2008). Exploring the effects of an "everyday" activity program on executive function and memory in older adults: Experience Corps ®. *The Gerontologist*, 48(6): 793-801.
28. Cattán, M., White, M., Bond, J. and Learmonth, A. (2005). Preventing social isolation and loneliness among older people: A systematic review of health promotion interventions. *Aging and Society*, 25(1), 41-67.
29. Cernea, M.M. (2003). The question not asked: when does displacement end? *Forced Migration Review*, 17: 24-26, May 2003.
30. ____ (2000). Risks, Safeguards, and Reconstruction: A Model for Population Displacement and Resettlement. In M.M. Cernea, and C. McDowell (Eds.), *Risks and Reconstruction: Experiences of Resettlers and Refugees*. Washington, D.C.: The World Bank.

31. Chaaya, M., Sibai, A., Fayad, R. and El-Roueiheb, Z. (2007). Religiosity and depression in older people: Evidence from underprivileged refugee and non-refugee communities in Lebanon. *Aging and Mental Health*, 11(1), 37-44.
32. Chapple, A. and Rogers, A. (1999). 'Self-care' and its relevance to developing demand management strategies: a review of qualitative research. *Health and Social Care in the Community*, 7(6): 445-454.
33. Charmaz, K. (2006). *Constructing Grounded Theory: A Practical Guide Through Qualitative Analysis*. London: Sage Publications.
34. ____ (1990). 'Discovering' chronic illness: using Grounded Theory. *Social Science & Medicine*, (30)11: 1161-1172.
35. Chou, K. L. (2007). Psychological distress in migrants in Australia over 50 years old: A longitudinal investigation. *Journal of Affective Disorders*, 98(1-2), 99-108.
36. Clarke (2005). *Situational Analysis: Grounded theory after the postmodern turn*. Thousand Oaks, CA: Sage Publications.
37. Cole, M.G., Bellavance, F. and Mansour, A. (1999). Prognosis of depression in elderly community and primary care populations: a systematic review and meta-analysis. *American Journal of Psychiatry*, 156(8): 1182-1189.
38. Cooper, A., Corrigan, P., and Watson, A. (2003). Mental illness stigma and care-seeking. *Journal of Nervous and Mental Disease*, 191: 339-341.
39. Corrigan, P. (2004). How stigma interferes with mental health care. *American Psychologist*, 59(7): 614-625.
40. Creswell, J. (2007). *Qualitative Inquiry & Research Design: Choosing Among Five Approaches, Second Edition*. Thousand Oaks, California: Sage Publications.

- 41.Cresswell, T. (1997). Chapter 16. Imagining the Nomad: Mobility and the Postmodern Primitive. In G. Benko and U., Strohmayr (Eds.) (pages 360-383). *Space and Social Theory. Interpreting Modernity and Postmodernity*. Oxford: Blackwell Publishers.
- 42.Crisp, J. (2004). The local integration and local settlement of refugees: a conceptual and historical analysis. *New Issues in Refugee Research Working Paper No. 102*. Geneva: United Nations High Commissioner for Refugees Evaluation and Policy Analysis Unit.
- 43.Cutchin, M. P. (2003). The process of mediating aging in place: a theoretically and empirically based model. *Social Science & Medicine*, 57, 1077-1090.
- 44.____ (2001). Deweyan integration: Moving beyond place attachment in elderly migration theory. *The International Journal of Aging and Human Development*, 52(1), 29-44.
- 45.Das, J., Do, Q., Friedman, J., McKenzie, D., and Scott, K. (2008). Poverty and mental health in the developing world: revisiting the relationship. *Social Science & Medicine*, 65(3):467-480.
- 46.Davidson, L. and Roe, D. (2007). Recovery from versus recovery in serious mental illness: One strategy for lessening confusion plaguing recovery. *Journal of Mental Health*, 16(4): 459-470.
- 47.Deleuze, G. and Guattari, F. (1976). *Rhizôme, introduction*. Paris: Editions de Minuit.
- 48.Derogatis, L.R., Lipman, R.S., Rickels, K., Uhlenhuth, E.H., and Covi, L. (1974) The Hopkins Symptom Checklist (HSCL): a self-report inventory. *Behavioral Sciences*, 19(1):1-15.

49. Dolidze, A., Tatishvili, M. and Chkhetia, L. (2005). *Study on Privatization of IDP Collective Centres in Georgia*. Tbilisi: United Nations Development Program and Swiss Agency for Development and Cooperation.
50. Durkheim (1951) (originally published 1897). *Suicide*. New York: Free Press.
51. Evans, G., Wells, N., and Moch, A. (2003). Housing and mental health: a review of the evidence and a methodological and conceptual critique. *Journal of Social Issues*, 59(3): 475-500.
52. Eytan, A., Gex-Fabry, M., Toscani, L., Deroo, L., Loutan, L., & Bovier, P. (2004). Determinants of postconflict symptoms in Albanian Kosovars. *The Journal of Nervous and Mental Disease*, 192(10): 664-671.
53. Fernandez, L. S., Byard, D., Lin, C. C., Benson, S. and Barbera, J. A. (2002). Frail elderly as disaster victims: Emergency management strategies. *Prehospital and Disaster Medicine*, 17(2), 67-74.
54. Ferris, E. (Ed.) (2011). *Resolving Internal Displacement: Prospects for Local Integration*. June 2011. Washington, D.C.: The Brookings Institution – London School of Economics Project on Internal Displacement.
55. Ferris, E., Mooney, E., and Stark, C. (2011). *From Responsibility to Response: Addressing National Approaches to Internal Displacement*. November 2011. Washington, D.C.: The Brookings Institution – London School of Economics Project on Internal Displacement.
56. Fosu, G. B. (1989). Access to Health Care in Urban Areas of Developing Societies. *Journal of Health and Social Behavior*, 30(4), 398-411.

57. Frederick, J.T., Steinman, L.E., Prohaska, T., Satariano, W.A., Bruce, M., Bryant, L. . .
 . Snowden, M. (2007). Community-based treatment of late life depression: an expert
 panel-informed literature review. *American Journal of Preventive Medicine*, 33(3):
 222-249.
58. Fullilove, M.T. (1996). Psychiatric implications of displacement: contributions from
 the psychology of place. *American Journal of Psychiatry*, 1516-1523.
59. Gallo, J.J. and Lebowitz, B.D. (1999). The epidemiology of common late life mental
 disorders in the community: Themes for the new century. *Psychiatric Services*, 50,
 1158–1166.
60. Gallo, J.J., Rebok, G.W., Tennstedt, S., Wadley, V. G., Horgas, A., and the ACTIVE
 study investigators (2003). Linking depressive symptoms and functional disability in
 late life. *Aging and Mental Health*, 7(6), 469-80.
61. Geertz, C. (1973). *The Interpretation of Cultures*. New York: Basic Books.
62. Gellis, Z.D., McGinty, J., Tierney, L., Jordan, C., Burton, J. and Misener, E. (2008).
 Randomized controlled trial of problem-solving therapy for minor depression in
 home care. *Research on Social Work Practice*, 18: 596-606.
63. Georgian Mental Health Coalition (2009). *Mental Health and Psycho-Social Needs
 of War-affected Population of Georgia*. Analytical Report. Tbilisi: Georgian Mental
 Health Coalition.
64. Glaser, B.G. (2012). Stop. Write! Writing Grounded Theory. *The Grounded Theory
 Review*, 11(1): 2-11.
65. Glaser, B.G. and Strauss, A.L. (1967). *The Discovery of Grounded Theory: Strategies
 for Qualitative Research*. Chicago: Aldine Publishing Company.

66. Glass, T.A., Freedman, M., Carlson, M.C., Hill, J., Frick, K.D., Ialongo, N., . . . Fried, L.P. (2004). Experience Corps: Design of an intergenerational program to boost social capital and promote the health of an aging society. *Journal of Urban Health*, 81(1): 94-105.
67. Global Initiative on Psychiatry (2009). *Draft Georgian Mental Health Policy*. Tbilisi: Global Initiative on Psychiatry.
68. Gordon-Finlayson, A. (2010). Chapter 9. QM2: Grounded Theory. In M.A. Forrester (Ed.), *Doing Qualitative Research in Psychology: A Practical Guide*, (pages 154-176). London: Sage Publications.
69. Gotsadze, G., Bennett, S., Ranson, K. and Gzirishvili, D. (2005). Health care-seeking behaviour and out-of-pocket payments in Tbilisi, Georgia. *Health Policy and Planning*, 20(4): 232-242.
70. Government of Georgia (2012). *Action Plan for the Implementation of the State Strategy on IDPs during 2012-2014*. Annex 1. Tbilisi: Ministry of Internally Displaced Persons From the Occupied Territories, Accommodation and Refugees of Georgia.
71. Government of Georgia (2007). *Decree #47 of the Government of Georgia on Approving of the State Strategy for Internally Displaced Persons – Persecuted*. 2 February 2007. Tbilisi: Government of Georgia.
72. Granovetter, M. (1985). Economic action and social structure: the problem of embeddedness. *American Journal of Sociology*, 91(3): 481-510.
73. Harpham, T. (2009). Urban health in developing countries: What do we know and where do we go? *Health & Place*, 15, 107-116.

74. Helly, D. and Gogia, G. (2005). Chapter 6: Georgian Security and the Role of the West. In Bruno Coppieters and Robert Legvold (Eds.), *Statehood and Security: Georgia after the Rose Revolution*, (pages 271-306). Cambridge: The MIT Press.
75. HelpAge International and United Nations High Commissioner for Refugees (UNHCR) (2000). *Older People in Disasters and Humanitarian Crises: Guidelines for Best Practice*. London: HelpAge International. Available from: <http://www.helpage.org/silo/files/older-people-in-disasters-and-humanitarian-crises-guidelines-for-best-practice.pdf>.
76. Herold, J.M. and Peavy, J.V. (2002). Chapter 11: Surveys and Sampling. In M. Gregg (Ed.), *Field Epidemiology (2nd Edition)* (pages 196-216). Oxford: Oxford University Press.
77. Hess, J.J., Malilay, J.N., and Parkinson, A.J. (2008). Climate change: the importance of place. *American Journal of Preventive Medicine*, 35(5): 468-478.
78. Holloway, I. and Brown, L. (2012). *Essentials of a Qualitative Doctorate*. Walnut Creek, CA: Left Coast Press.
79. Huang, B., Cornoni-Huntley, J., Hays, J., Huntley, R., Galanos, A., Blazer, D. (2000). Impact of depressive symptoms on hospitalization risk in community dwelling older persons. *Journal of the American Geriatrics Society*, 48, 1279–1284.
80. Ingleby, D. (Ed.) (2005). 'Editor's Introduction.' Chapter 1 in D. Ingleby (Ed.), *Forced Migration and Mental Health: Rethinking the Care of Refugees and Displaced Persons*, (pages 1-28). New York: Springer Science.
81. Institute for Policy Studies (2008). *Rapid Needs Assessment of Internally Displaced Women as a Result of August 2008 Events in Georgia: Findings and*

- Recommendations*. October 2008. Tbilisi: United Nations Development Fund for Women (UNIFEM) and the Institute for Policy Studies.
82. Inter-Agency Standing Committee (IASC) (2007). *IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings*. Geneva: Inter-Agency Standing Committee.
83. Internal Displacement Monitoring Centre (IDMC) (2013a). 'Georgia Country Page.' Last updated 31 December 2012. Available from: <http://www.internal-displacement.org/countries/georgia>.
84. ____ (2013b). *Global Overview 2012: People internally displaced by conflict and violence*. Geneva: Internal Displacement Monitoring Centre and Norwegian Refugee Council.
85. ____ (2012a). 'Mental health of IDPs.' Last updated 19 March 2012. Available from: [http://www.internal-displacement.org/idmc/website/countries.nsf/\(httpEnvelopes\)/9C67D59952A3E2A1C12579C7000A872B?OpenDocument](http://www.internal-displacement.org/idmc/website/countries.nsf/(httpEnvelopes)/9C67D59952A3E2A1C12579C7000A872B?OpenDocument).
86. ____ (2012b). 'Freedom of movement to and from Abkhazia.' Last updated 18 March 2012. Available from: [http://www.internal-displacement.org/idmc/website/countries.nsf/\(httpEnvelopes\)/113021D4AF02B329C12579C600087B45?OpenDocument](http://www.internal-displacement.org/idmc/website/countries.nsf/(httpEnvelopes)/113021D4AF02B329C12579C600087B45?OpenDocument).
87. Jacobson, N. and Greenley, D. (2001). What is recovery? A conceptual model and explication. *Psychiatric Services*, 52(4).
88. Jikia, T. (2013). Personal Correspondence. September 23, 2013.

- 89.Kasl S. (1979). Changes in mental health status associated with job loss and retirement. In J. Barrett(ed), *Stress and Mental Disorder*. New York: Raven Press.
- 90.Kawachi, I. and Berkman, L.F. (2001). Social ties and mental health. *Journal of Urban Health*, 78(3): 458-467.
- 91.Kessler, R.C., Angermeyer, M., Anthony, J.C., Graaf, R.D., Demyttenaere, K., Gasquet, I. . . . Üstün, T.B. (2007). Lifetime prevalence and age-of-onset distributions of mental disorders in the World health Organization's World Mental Health Survey Institute, *World Psychiatry*, 6(3): 168-176.
- 92.Keyes, C.L.M. and Michalec, B. (2010). Chapter 7: Viewing Mental Health from the Complete State Paradigm. In T. L. Scheid and T. N. Brown (Eds.), *A Handbook for the Study of Mental Health: Social Contexts, Theories, and Systems, Second Edition*, (pages 125-134). Cambridge: Cambridge University Press.
- 93.Kohn, R., Levav, I., Garcia, I.D., Machuca, M.E. and Tamashiro, R. (2005). Prevalence, risk factors and aging vulnerability for psychopathology following a natural disaster in a developing country. *International Journal of Geriatric Psychiatry*, 20(9): 835-841.
- 94.Kohrt, B.A. and Hruschka, D.J. (2010). Nepali Concepts of Psychological Trauma: the Role of Idioms of Distress, Ethnopsychology and Ethnophysiology in Alleviating Suffering and Preventing Stigma. *Culture, Medicine and Psychiatry*, 34(2): 322-352.
- 95.Koochek, A., Montazeri, A., Johansson, S. E. and Sundquist, J. (2007). 'Health-related quality of life and migration: A cross-sectional study on elderly Iranians in Sweden.' *Health and Quality of Life Outcomes*, 5(60).

- 96.Koppensteiner, N. (2009). On Moving: Nomadism and (In)Security. In W. Sützl, and G. Cox (Eds.), *Creating Insecurity: Art and Culture in the Age of Security*. New York: Autonomedia.
- 97.Kurshitashvili, N. (2012). The impact of socially ir/responsible resettlement on the livelihoods of internally displaced persons in Georgia. *Refugee Survey Quarterly*, 31(2): 98-118.
- 98.Laor, N., Wolmer, L., Friedman, Z., Spirman, S. and Knobler, H. (2005). Disaster Intervention: An Integrative Systemic Perspective for Health and Social Service Professionals. In M. Friedman and A. Mikus-Kos (Eds.), *Promoting the Psychosocial Well Being of Children Following War and Terrorism*, (pages 33-44). Amsterdam: IOS Press.
- 99.Lawler, K. (2001). *Aging in Place: Coordinating Housing and Health Care Provision for America's Growing Elderly Population*. Cambridge: Joint Center for Housing Studies of Harvard University and Neighborhood Reinvestment Corporation.
- 100.Lay, B., Lauber, C., Nordt, C., and Rossler, W. (2006). Patterns of inpatient care for immigrants in Switzerland: A case control study. *Social Psychiatry and Psychiatric Epidemiology*, 41(3), 199-207.
- 101.Lerner, V., Kanevsky, M., and Witztum, E. (2008). The influence of immigration on the mental health of those seeking psychiatric care in Southern Israel: a comparison of new immigrants to veteran residents. *Israel Journal of Psychiatry and Related Sciences*, 45(4), 291-298.
- 102.Levkoff, S.E., Macarthur, I.W., and Bucknall, J. (1995). Elderly Mental Health in the Developing World. *Social Science & Medicine*, 41(7): 983-1003.

103. Lewis, D.C. (2009). Aging out of place: Cambodian refugee elders in the United States. *Family and Consumer Sciences Research Journal*, 37(3), 376-393.
104. Lin, N., Ye, X. and Ensel, W.M. (1999). Social support and depressed mood: a structural analysis. *Journal of Health and Social Behavior*, 40: 344-359.
105. Link, B., Yang, L., Phelan, J., and Collins, P. (2004). Measuring mental illness stigma. *Schizophrenia Bulletin*, 30(3): 511-541.
106. Litwin, H. (2006). Social networks and self-rated health: a cross-cultural examination among older Israelis. *Journal of Aging and Health*, 18(3), 335-358.
107. Loughry, M. (2007). 'Psychosocial Assistance', lecture delivered at Queen Elizabeth House, Department of International Development, University of Oxford, February 2007.
108. Luber, M., Meyers, B., Williams-Russo, P., Hollenberg, J.P., DiDomenico, T.N., Charlson, M.E., and Alexopoulos, G.S. (2001). Depression and service utilization in elderly primary care patients. *The American Journal of Geriatric Psychiatry*, 9, 169-176.
109. Martin, S. and Mooney, E. (2007). Criteria for Determining the End of Displacement: Three Options for Consideration. In *When Displacement Ends: A Framework for Durable Solutions*, (pages 39-40). Washington D.C.: The Brookings Institution – University of Bern Project on Internal Displacement.
110. Maxwell, J.A. (2013). *Qualitative Research Design: An Interactive Approach*. 3rd Edition. Applied Social Research Methods Series. London: Sage Publications.

111. Miller, K.E. and Rasco, L.M. (2004). *The Mental Health of Refugees: Ecological Approaches to Healing and Adaptation*, Mahwah, New Jersey: Lawrence Erlbaum Associates.
112. Milner, P., Chanturidze, T., and Levett, J. (2009). *Health Promotion Strategy for Georgia 2010-2015*. Tbilisi: Policy Management Consulting Group and Oxford Policy Management.
113. Ministry of Internally Displaced Persons from the Occupied Territories, Accommodation and Refugees of Georgia (2013). IDP Figures. Available from: <http://mra.gov.ge/main/ENG#section/89>.
114. Ministry of Labour, Health, and Social Affairs (2011). *National Health Care Strategy for 2011-15*. Tbilisi: Government of Georgia.
115. Mitchneck, B., Mayorova, O.V., and Regulska, J. (2009). "Post"-Conflict Displacement: Isolation and Integration in Georgia. *Annals of the Association of American Geographers*, 9(5):1022-1032.
116. Mooney, E. (2003). *When does internal displacement end?* Paper presented at the conference, "Researching Internal Displacement: State of the Art," Trondheim, Norway, February 2003.
117. Morrison, T. (1993). *Playing in the Dark: Whiteness and the Literary Imagination*. New York: Vintage Books.
118. Morse, J. M. (2012). *Qualitative Health Research. Creating a New Discipline*. Walnut Creek, CA.: Left Coast Press.

119. Mueser, K., Corrigan, P., Hilton, D., Tanzman, B., Schaub, A., Gingerich, S. . . Herz, M.I. (2002). Illness management and recovery: a review of the research. *Psychiatric Services*, 53(10): 1272-1284.
120. Murray, L., Singh, N.S., Surkan, P.J., Semrau, K., Bass, J. and Bolton, P. (2012). A qualitative study of Georgian youth who are on the street or institutionalized. *International Journal of Pediatrics*, Article ID 921604, 11 pages, doi:10.1155/2012/921604.
121. National Institute of Mental Health (2010). *Mental Health Medications*. Bethesda: U.S. Department of Health and Human Services and National Institutes of Health.
122. Nguyen, V-K, Ako, C.Y., Niamba, P., Sylla, A. and Tiendrébéogo, I. (2007). Adherence as therapeutic citizenship: impact of the history of access to antiretroviral drugs on adherence to treatment. *AIDS*, 21(suppl 5): S31-S35.
123. Nodia, G. (2005). Chapter 1: Georgia: Dimensions of Insecurity. In Bruno Coppieters and Robert Legvold (Eds.), *Statehood and Security: Georgia after the Rose Revolution*, (pages 39-82). Cambridge: The MIT Press.
124. Parsons, T. (1978). 'The sick role and the role of the physician reconsidered,' in *Action Theory and the Human Condition*. The Free Press: New York, New York.
125. Patel, V., Araya, R., Chatterjee, S., Chisholm, D., Cohen, A., De Silva, M. . . van Ommeren, M. (2007). Treatment and prevention of mental disorders in low-income and middle-income countries. *The Lancet*, 370: 991-1005.
126. Patel, V. and Kleinman, A. (2003). Poverty and common mental disorders in developing countries. *Bulletin of the World Health Organization*, 81(8): 609-615.

127. Patel, V. and Prince, M. (2001). Ageing and mental health in a developing country: who cares? Qualitative studies from Goa, India. *Psychological Medicine*, 31, 29-38.
128. Pelkmans, M. (2006). *Defending the Border: Identity, Religion, and Modernity in the Republic of Georgia*. Ithaca: Cornell University Press.
129. Perese, E.F. and Wolf, M. (2005). Combating loneliness among persons with severe mental illness: social network interventions' characteristics, effectiveness, and applicability. *Issues in Mental Health Nursing*, 26:591-609.
130. Pescosolido, B. (2006). Of pride and prejudice: the role of sociology and social networks in integrating the health sciences. *Journal of Health and Social Behavior*, 47(3): 189-208.
131. Pescosolido, B. (1991). Illness Careers and Network Ties: A Conceptual Model of Utilization and Compliance. *Advances in Medical Sociology*, 2: 161-184.
132. Pescosolido, B. and Boyer, C. (2010). 'Chapter 21: Understanding the context and dynamic social processes of mental health treatment.' Pp. 420-438 in A.V. Horwitz and T.L. Scheid, eds., *A Handbook for the Study of Mental Health: Social Contexts, Theories, and Systems, 2nd Edition*. Cambridge University Press: New York, New York.
133. Pescosolido, B.A., Garner, C., and Lubell, K. (1998). How people get into mental health services: Stories of choice, coercion, and "muddling through" from first timers. *Social Science & Medicine*, 46, 275-286.
134. Prince, M., Patel, V., Shekhar, S., Maj, M., Maselko, J., Phillips, M.R. and Rahman, A. (2007). No health without mental health. *Lancet*, 370: 859-877.

135. Psychosocial Working Group (2003). 'Psychosocial Intervention in Complex Emergencies: A Conceptual Framework.' Working Paper. Edinburgh: The Psychosocial Working Group.
136. Pupavac, V. (2006). Chapter 2: Humanitarian Politics and the Rise of International Disaster Psychology. In Reyes, G. and Jacobs, G.A., (Eds.) *Handbook of International Disaster Psychology : Volume 1—Fundamentals and Overview*. Westport, Connecticut: Praeger Perspectives.
137. Pupavac, V. (2002). Afghanistan: The Risks of International Psychosocial Risk Management. In *Health in Emergencies Newsletter*, World Health Organization, Issue No. 12, March 2002.
138. Rasco, L.M. and Miller, K.E. (2004). Chapter 11: Innovations, Challenges, and Critical Issues in the Development of Ecological Mental Health Interventions with Refugees. In K.E. Miller and L.M. Rasco (Eds.), *The Mental Health of Refugees: Ecological Approaches to Healing and Adaptation*, (pages 375-416). Mahwah, N.J.: Lawrence Erlbaum Associates.
139. Rebok, G., Carlson, M.C., Glass, T.A., McGill, S., Hill, J., Wasik, B.A. . . . Rasmussen, M.D. (2004). Short-term impact of Experience Corps® participation on children and schools: results from a pilot randomized trial. *Journal of Urban Health*, 81(1): 79-93.
140. Robinson, C. (2010). Personal Correspondence. May 2010.
141. Rogler, L. and Cortes, D. (1993). 'Help-seeking pathways: A unifying concept in mental health care.' *American Journal of Psychiatry*, 150(4): 554-561.

142. Rose, L., Mallinson, R.K., and Walton-Moss, B. (2002). A grounded theory of families responding to mental illness. *Western Journal of Nursing Research*, 24(5): 516-536.
143. Rowles, G. (1983). Place and personal identity in old age: Observations from Appalachia. *Journal of Environmental Psychology*, 3, 299–313.
144. Sabin, M., Lopes Cardozo, B., Nackerud, L., Kaiser, R. and Varese, L. (2003). Factors associated with poor mental health among Guatemalan refugees living in Mexico 20 years after civil conflict. *JAMA*, 290(5): 635-642.
145. Said, E. (1983). Opponents, Audiences, Constituencies and Community. In W.J.T. Mitchell (Ed.), *The Politics of Interpretation*, (page 7). Chicago: University of Chicago Press.
146. Saldana, J. (2013). *The Coding Manual for Qualitative Researchers, Second Edition*. London: Sage Publications.
147. Saleri, S. (2010). “On Nomadism: Interview with Rosi Braidotti.” Available at: <http://www.euroalter.com/2010/on-nomadism-interview-with-rosi-braidotti/>
148. Salih, M. and Galappatti, A. (2006). Integrating a psychosocial perspective into poverty reduction: the case of a resettlement project in northern Sri Lanka. *Intervention: International Journal of Mental Health, Psychosocial Work and Counselling in Areas of Armed Conflict*, 4(2): 126-144.
149. Saraceno, B., van Ommeren, M., Batniji, R., Cohen, A., Gureje, O., Mahoney, J. . . . Underhill, C. (2007). Barriers to improvement of mental health services in low-income and middle-income countries. *The Lancet*, 370: 1164-74.
150. Sartorius, N. (2007). Stigma and mental health. *The Lancet*, 370(9590): 810-811.

- 151.Sermijn, J., Devlieger, P. and Loots, G. (2008). The narrative construction of the self: selfhood as a rhizomatic story. *Qualitative Inquiry*, 14(4): 632-650.
- 152.Sharashidze, M., Naneishvili, G., Silagadze, T., Begiashvili, A., Sulaberidze, B. and Beria, Z. (2004). Georgia mental health country profile. *International Review of Psychiatry*, 16(1-2): 107-116.
- 153.Shepherd, G., Boardman, J., and Slade, M. (2008). *Making Recovery a Reality*. London: Sainsbury Centre for Mental Health.
- 154.Shin, J. (2002). Help-seeking behaviors by Korean immigrants for depression. *Issues in Mental Health Nursing*, 23(5), 461-476.
- 155.Silove, D. (2005). 'From Trauma to Survival and Adaptation: Towards a framework for guiding mental health initiatives in post-conflict societies', Chapter 2 in Ingleby, D. (ed.) *Forced Migration and Mental Health: Rethinking the Care of Refugees and Displaced Persons*, New York: Springer Science.
- 156.Silove, D., Steel, Z. and Psychol, M. (2006). Understanding community psychosocial needs after disasters: Implications for mental health services. *Journal of Postgraduate Medicine*, 52(2): 121-125.
- 157.Singh, N. and Robinson, C. (2010). Social support systems among urban IDPs in Georgia, *Forced Migration Review*, 34, Issue on Urban Displacement, February 2010.
- 158.Skopec, C., Valeeva, N., and Baca, M.J. (2010). Anticipating the unexpected: urban refugee programming in Jordan. *Middle East Institute Fondation pour la Recherche Stratégique*, November 1, 2010.

159. Speck, V., Nyklicek, I., Smits, N., Cuijpers, P., Riper, H., Keyzer, J. and Pop, V. (2007). Internet-based cognitive behavioural therapy for subthreshold depression in people over 50 years old: a randomized controlled trial. *Psychological Medicine*, 37: 1797-1806.
160. Sphere Project (2004). *Sphere, Humanitarian Charter and Minimum Standards in Disaster Response—Mental and Social Aspects*, Geneva, The Sphere Project. Available from: <http://ocw.jhsph.edu/courses/RefugeeHealthCare/PDFs/SphereProjectHandbook.pdf>. Accessed 15 November 2013.
161. Srebnik, D. and Cauce, A. (1996). Help-seeking pathways for children and adolescents. *Journal of Emotional & Behavioral Adolescents*, 4(4): 210-221.
162. Strang, A. and Ager, A. (2005). Psychosocial Interventions: Key Issues Facing Practitioners. In M. Friedman and A. Mikus-Kos (Eds.), *Promoting the Psychosocial Well Being of Children Following War and Terrorism*, (pages 61-72). Amsterdam: IOS Press.
163. Strauss, A.L. and Corbin, J.M. (1990). *Basics of Qualitative Research: Grounded Theory Procedures and Techniques*. Thousand Oaks, CA: Sage Publications.
164. Substance Abuse and Mental Health Services Administration (SAMHSA) (2011). SAMHSA announces a working definition of “recovery” from mental disorders and substance use disorders. *SAMHSA News Release*. 22 December, 2011. Available from: <http://www.samhsa.gov/newsroom/advisories/1112223420.aspx>.

- 165.Sumbadze, N. and Tarkhan-Mouravi, G. (2003). *Working paper on IDP vulnerability and economic self-reliance*. Tbilisi: United Nations Development Program.
- 166.Summerfield, D. (2008). How scientifically valid is the knowledge base of global mental health? *BMJ*, 336, 992-994.
- 167.Tondora, J., Heerema, R., Delphin, M., Andres-Hyman, R., O'Connell, M.J. and Davidson, L. (2008). *Practice Guidelines for Recovery-Oriented Care for Mental Health and Substance Use Conditions, Second Edition*, for the Connecticut Department of Mental Health and Addiction Services. Yale University Program for Recovery and Community Health.
- 168.Tsereteli, A. *Dawn*.
- 169.Tuan, Y. (1977). *Space and Place: The Perspective of Experience*. Minneapolis: University of Minnesota Press.
- 170.Tuhiwai Smith, L. (2012). *Decolonizing Methodologies: Research and Indigenous Peoples, 2nd Edition*. London: Zed Books.
- 171.United Nations High Commissioner for Refugees (UNHCR) (2013). *UNHCR Statistical Online Population Database: Sources, Methods and Data Considerations*. 1 January 2013. Available from:
<http://www.unhcr.org/45c06c662.html>.
- 172.____(2012). *“Returned but still reintegrating”: Participatory assessment of the humanitarian situation and progress made in the re-integration process of IDPs who returned to the Shida Kartli region, Georgia*. August 2012. Tbilisi: UNHCR Georgia.

173. United Nations Office for the Coordination of Humanitarian Affairs (OCHA) (2003). *Georgia Humanitarian Situation and Strategy*. 13 February 2003. Tbilisi: United Nations OCHA.
174. ____ (2001). *Guiding Principles on Internal Displacement*. New York: United Nations.
175. United Nations Population Fund (UNFPA) and HelpAge International (2012). *Ageing in the 21st Century: A Celebration and a Challenge*. Available from: <http://unfpa.org/ageingreport/>.
176. Unutzer, J., Patrick, D., Simon, G., Grembowski, D., Walker, E., Rutter, C. and Katon, W. (1997). Depressive symptoms and the cost of health services in HMO patients aged 65 years and older: A 4-year prospective study. *JAMA*, 277(20), 1618–1623.
177. Vandemark, L.M. (2007). Promoting the sense of self, place, and belonging in displaced persons: the example of homelessness. *Archives of Psychiatric Nursing*, 21(5): 241-248.
178. van de Put, W. (2002). Addressing mental health in Afghanistan. *The Lancet*, 360(1): 41-42.
179. van der Wurff, F.B., Beekman, A.T.F., Dijkshoorn, H., Spijker, J.A., Smits, C.H.M., Stek, M.L., and Verhoeff, A. (2004). Prevalence and risk-factors for depression in elderly Turkish and Moroccan migrants in the Netherlands. *Journal of Affective Disorders*, 83(1), 33-41.
180. van Ommeren, M., Morris, J., and Saxena, S. (2006). Integrated programme planning and psychosocial concepts in humanitarian response: a response to

- Williamson and Robinson. *Intervention: International Journal of Mental Health, Psychosocial Work and Counselling in Areas of Armed Conflict*, 4(1): 26-28.
181. Vatak, S. (1990). 'To be a burden on others': dependency anxiety among the elderly in India. In O.M. Lynch (Ed.), *Divine Passions: The Social Construction of Emotion in India*, (pages 64 -68). Berkeley, CA: University of California Press.
182. von Lersner, U., Wiens, U., Elbert, T., and Neuner, F. (2008). Mental health of returnees: refugees in Germany prior to their state-sponsored repatriation. *International Health and Human Rights*, 8(8).
183. Wang, P.S., Berglund, P., Olfson, M., Pincus, H.A., Wells, K.B., Kessler, R.C., (2005). Failure and delay in initial treatment contact after first onset of mental disorders in the National Comorbidity Survey Replication. *Archives of General Psychiatry*, 62(6): 603-613.
184. Weich, S., Blanchard, M., Prince, M., Burton, E., Erens, B., and Sproston, K. (2002). Mental health and the built environment: cross-sectional survey of individual and contextual risk factors for depression. *British Journal of Psychiatry*, 180: 428-433.
185. Weine, S., Kulauzovic, Y., Klebic, A., Besic, S., Mujagic, A., Muzurovic, J. . . . Rolland, J. (2008). Evaluating a multiple-family group access intervention for refugees with PTSD. *Journal of Marital and Family Therapy*, 34(2): 149-164.
186. Weine, S., Vojvoda, D., Becker, D., McGlashan, T., Hodzic, E., Laub, D. . . . Lazrove, S. (1998). PTSD symptoms in Bosnian refugees 1 year after resettlement in the United States. *American Journal of Psychiatry*, 155, 562-564.
187. Weller, S.C. and Romney, A.K. (1988). *Systematic Data Collection*. Newbury Park, California: Sage Publications.

188. Wertz, M.S., Nosek, M., McNiesh, S., and Marlow, E. (2011). The composite first person narrative: texture, structure, and meaning in writing phenomenological descriptions. *International Journal of Qualitative Studies in Health and Well-being*, 6(5882), DOI: 10.3402/qhw.v6i2.5882.
189. White, L., Blazer, D., Fillenbaum, G. (1990). Related health problems. In J. Cornoni-Huntley, D. Blazer, M. Lafferty, D. Everett, D. Brock, M. Farmer (Eds.), *Established Populations for Epidemiologic Studies of the Elderly*, (pages 70-85). Bethesda: National Institute on Aging.
190. Williams, A. (1998). Therapeutic landscapes in holistic medicine. *Social Science & Medicine*, 46(9): 1193-1203.
191. Williamson, J. and Robinson, M. (2006). Psychosocial Interventions, or Integrated Programming for Well-Being? *Intervention: International Journal of Mental Health, Psychosocial Work and Counselling in Areas of Armed Conflict*, 4(1): 4-25.
192. World Bank (2005). Mental Health in Conflict Settings: Conceptual Framework and Approaches. *Health Nutrition and Population (HNP) Discussion Paper Series*, Washington. D.C.: World Bank.
193. World Health Organization (WHO) (2010). WHO Age-Friendly Environments Programme webpage. Available from:
http://www.who.int/ageing/age_friendly_cities/en/index.html.
194. ____ (2008). *mhGAP Mental Health Gap Action Programme: Scaling up care for mental, neurological, and substance use disorders*. Geneva: WHO.
195. ____ (2003). *The Optimal Mix of Services for Mental Health: WHO Pyramid Framework*. The World Health Organization MIND (Mental Improvement for

Nations Development) Project, Department of Mental Health and Substance Abuse.
Geneva: World Health Organization.

196. ____ (2002). *Health in Emergencies Newsletter*, Issue No. 12, March 2002.
197. ____ (2001). 'Background paper for the technical consultation on effective coverage of health systems.' 27-29 August, Rio de Janeiro, Brazil.
198. (The) WHO World Mental Health Survey Consortium (2004). Prevalence, severity, and unmet need for treatment of mental disorders in the World Health Organization World Mental Health Surveys. *JAMA*, 291(21): 2581-2590.
199. Zetter, R. (1991). Labelling refugees: forming and transforming a bureaucratic identity. *Journal of Refugee Studies*, 4(1): 39-62.
200. Zoidze, A. and Djibuti, M. (2004). *IDP Health Profile Review in Georgia*. Prepared under the New Approach to IDP Assistance Initiative, Tbilisi.

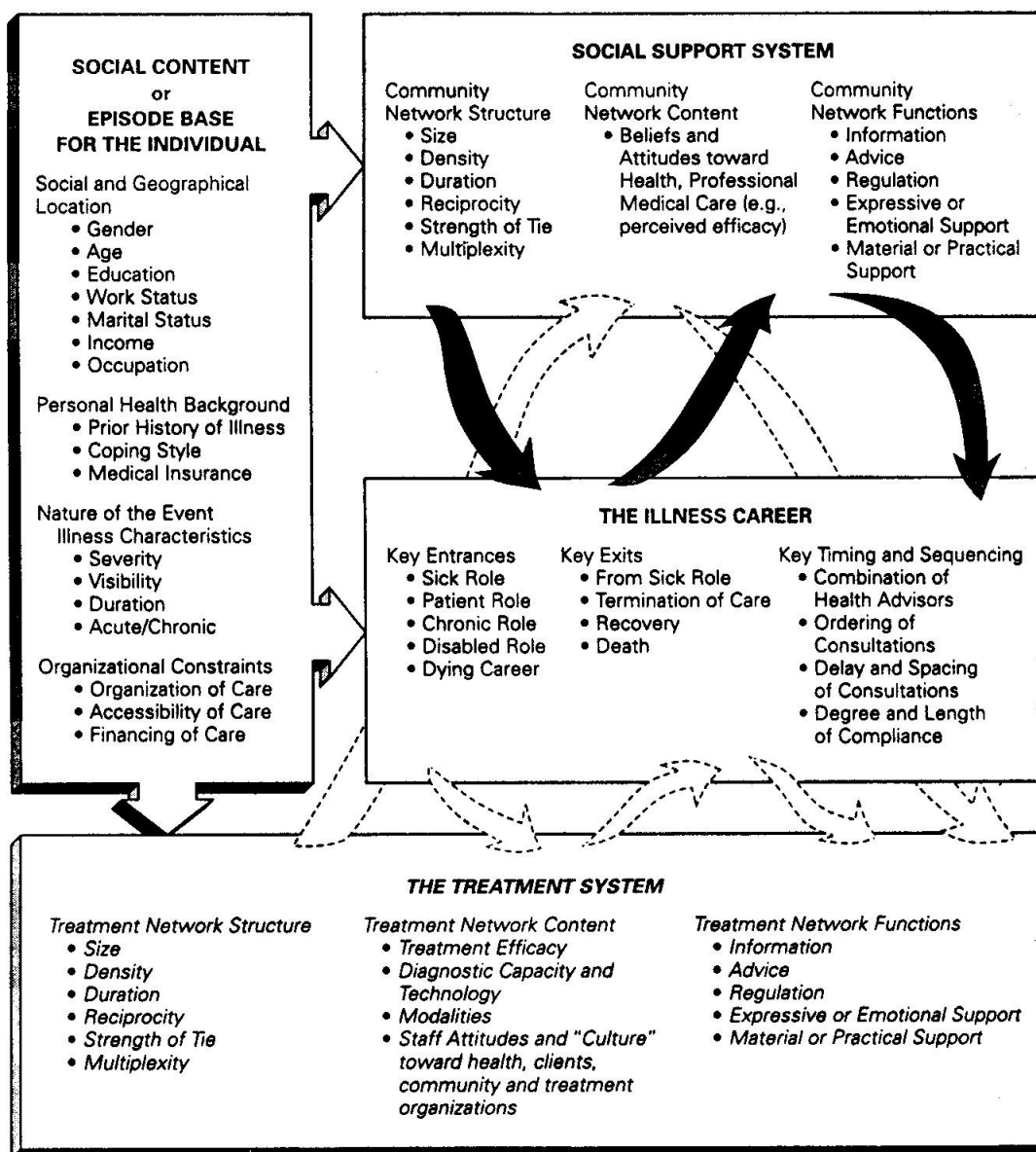
APPENDICES

Appendix A. Map of Georgia



Appendix B. Diagrams of Key Conceptual Models

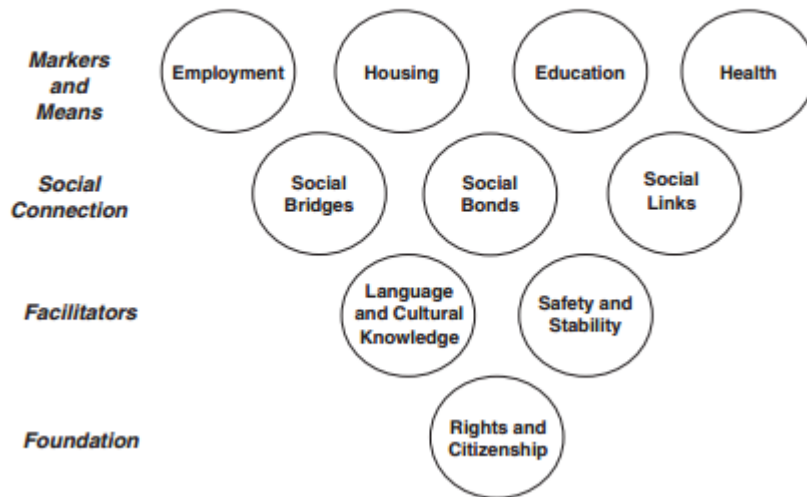
1. Network Episode Model Phase II (Pescosolido, 2006)



2. Conceptual Framework of Integration Among Displaced Persons (Ager & Strang, 2008)

Figure 1

A Conceptual Framework Defining Core Domains of Integration



3. Optimal Mix of Services (World Health Organization, 2003)



4. Table of Factors Contributing to Positive Mental Health (Keyes & Michalec, 2010)

Table 7.1. *Factors and dimensions reflecting mental health as flourishing*

Hedonia

Emotional well-being

- 1) *Positive affect*: is cheerful, interested in life, in good spirits, happy, calm and peaceful, full of life
 - 2) *Avowed quality of life*: is mostly or highly satisfied with life overall or in domains of life positive functioning
 - 3) *Self-acceptance*: holds positive attitudes toward self, acknowledges and likes most parts of self, personality
 - 4) *Personal growth*: seeks challenge, has insight into own potential, feels a sense of continued development
 - 5) *Purpose in life*: finds own life has a direction and meaning
 - 6) *Environmental mastery*: exercises ability to select, manage, and mold personal environs to suit needs
 - 7) *autonomy*: is guided by own, socially accepted, internal standards and values
 - 8) *Positive relations with others*: has, or can form, warm, trusting personal relationships
 - 9) *Social acceptance*: holds positive attitudes toward, acknowledges, and is accepting of human differences
 - 10) *Social actualization*: believes people, groups, and society have potential and can evolve or grow positively
 - 11) *Social contribution*: sees own daily activities as useful to and valued by society and others
 - 12) *Social coherence*: has interest in society and social life and finds them meaningful and somewhat intelligible
 - 13) *Social integration*: has a sense of belonging to, and comfort and support from, a community
-

Appendix C. Key Normative Guidelines

1. The Guiding Principles on Internal Displacement (United Nations Office for the Coordination of Humanitarian Affairs (OCHA), 2001)

“Principle 19: All wounded and sick internally displaced persons as well as those with disabilities shall receive to the fullest extent practicable and with the least possible delay, the medical care and attention they require, without distinction on any grounds other than medical ones. When necessary, internally displaced persons shall have access to psychological and social services.”

2. The Georgian State Strategy for IDPs (Government of Georgia, 2007)

“3.1. Improvement of living conditions of IDPs depends upon access to adequate social services, first of all in the spheres of healthcare and education. In order to achieve these goals, the state strategy envisages implementation of following activities:

- a) A survey of the health status and morbidity of IDPs should be conducted. Special attention should be paid to researching the prevalence of diseases of probable high risk among IDPs. It is recommended to elaborate medical and psycho-social assistance/rehabilitation programs for IDPs;
- b) For the extremely vulnerable groups of IDPs (such as people with disabilities, vulnerable elderly people, single mothers and their CHILDREN, orphans etc.), who do not possess the necessary resources for achieving self-reliance, the State Strategy envisages the timely identification of their needs and their inclusion in existing programs of humanitarian assistance or of targeted care and social and home-care programs, or if needed, elaboration of special programs for them;”

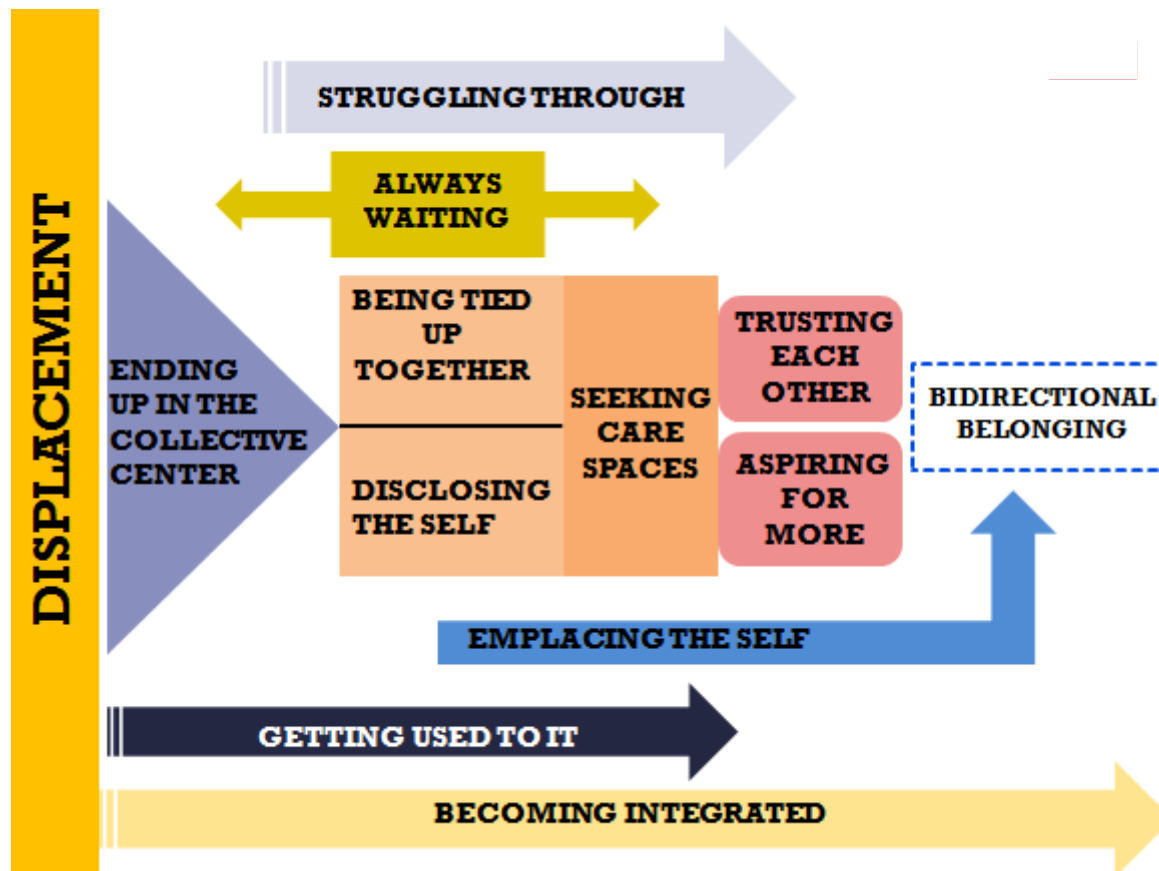
Appendix D. List of Service Sites Visited

1. Long-term inpatient psychiatric facility in Tbilisi
2. Crisis/ emergency care inpatient psychiatric facility in Tbilisi
3. Outpatient psychiatric unit in Zugdidi
4. NGO in Zugdidi that helps individuals with substance use recovery
5. NGO in Zugdidi that helps disabled individuals and older adults
6. Alternative medicine phitotherapy (herbal therapy) clinic in Tbilisi
7. Outpatient medical facility in Tbilisi
8. Offices of several NGOs in Tbilisi, Gori, Zugdidi, and Akhmeta that provide MHPSS and other services to conflict-affected populations
9. UNHCR in Tbilisi, Gori, and Zugdidi
10. UNHCR implementing partners in Gori and Zugdidi
11. U.S. State Department offices in Tbilisi
12. International humanitarian organizations

Appendix E. Age and Gender of Sample of 39 IDPs Interviewed in 2010-11

No.	Sex	Age	Location	No.	Sex	Age	Location
1	F	54	Zugdidi collective center A	21	M	52	“
2	F	29	“	22	F	22	“
3	F	70	“	23	F	22	“
4	M	32	“	24	M	18	“
5	F	79	“	25	F	48	“
6	M	27	“	26	F	24	Zugdidi collective center D
7	F	42	“	27	F	73	“
8	F	39	“	28	F	69	“
9	M	52	“	29	F	46	“
10	F	40	Zugdidi collective center B	30	F	47	“
11	F	43	“	31	F/F	26/22 (sister is proxy)	Zugdidi collective center E
12	F	42	“	32	M	73	Zugdidi private accommodation
13	F	43	“	33	M/M	32/___ (father is proxy)	Village F private accommodation
14	F	28	“	34	M	42	Village G private accommodation
15	M	45	“	35	M/F	39/58 (aunt is proxy)	Village H private accommodation
16	F	76	“	36	F	35	Zugdidi collective center I
17	F	39	“	37	F	22	Anaklia collective center J
18	F	65	Zugdidi collective center C	38	M	22	Poti new apartments
19	M	28	“	39	M	18	“
20	F	27	“				

Appendix F. Visual Diagram of Selected Constructs from Study 2



This diagram illustrates the dynamic interactions and relationships among a number of key theoretical constructs from Study 2. IDP participants described progressing or moving through linked experiences represented by these constructs. Although this progression is not linear, and individuals described getting ‘stuck’ in or cycling back to different experiences, feelings, and processes, there is a temporal element at play as individuals move forward from the point of displacement. Individuals described struggling through and getting used to displacement, dreaming of the past and the possibility of return to their homelands, and ultimately wanting to emplace themselves, feel a sense of belonging, and aspire for more. This is a cyclical process, and at the core of it is how individuals relate to and trust each other, as well as how they seek care and social support from one another.

Appendix G. Additional Text: Backgrounds of IDP Participants in Study 2

Zugdidi Based IDPs: At the time of her interview, Eka is 37 years old; she has two school aged children. She wants to pursue job opportunities but feels that she has to be at home for her children when they return home from school. She moved to the collective center after studying in Tbilisi, post-displacement, and then living in Poti, another city in western Georgia, and has been displaced for 23 years. Ketevan is 51 years old. She is from Gali in Abkhazia, has been displaced for 20 years, and has lived in the collective center for 15 years. She has a husband who became an amputee after a mine blast in 1993. She has two sons, one daughter, and grandchildren. She works as a tailor, but her family mostly survives on the pensions of her husband and mother-in-law. Teá is 19 years old and a second year student at a university in Zugdidi. Her mother and younger sister live in Tbilisi because of her mother's health problems. Her family initially lived in Moscow after displacement and has lived in this collective center for about 12 years. Teá has been displaced since she was eight months old. Nana is 40 years old, widowed—her husband died in the war—and lives with her three teenage children. They have lived in the collective center for about 15 years. Nana went to university but did not receive a diploma because her final exams coincided with the war.

Tbilisi Based IDPs: Tamriko is 44 years old and displaced from the village of Samachablo in South Ossetia. She has lived in the compact settlement for 22 years since the war. She lives with her husband, son, and daughter. Her sister-in-law and her family were displaced from South Ossetia during the 2008 war and live in one of the new IDP

settlements, Tserovani, outside Tbilisi. Tamriko spends her time carrying out chores at home and volunteering at NGO X, an organization that works with women and conflict-affected populations. She works as a trainer and office manager at this NGO. She used to work in broadcast television. Lika is 42 years old and lives with her husband and three adult children. She is a journalist by training and has a temporary job with a local political party. They have been living in the settlement for 16 years. She is from Abkhazia, and her husband is from South Ossetia. She takes care of her home and family, including her 22 year old daughter who was injured in a car accident. Mari is 44 years old and has been displaced for 20 years. She lives with her husband and three children. Her parents also live in the settlement. She has never worked because she got married and had children after finishing secondary school. Giorgi is 50 years old and lives with his wife, a veterinarian by training who currently stays at home, and his two teenage children. Giorgi used to be a teacher of physics but has not taught since living in Tbilisi. Here, he has worked in many different positions, including in the market, as a taxi driver, and in construction. His family has been living in the settlement for 13 years and before that, in Zugdidi for six years. Irakli is 27 years old and displaced from the district of Snauri in South Ossetia. He lives with his brother, sister, father and grandmother. He lived with his mother in Rustavi until his mother died from lung cancer in 1999. At 14 years old he moved to the settlement to live with his grandparents and father. Irakli's family still owns the house in Rustavi. Irakli is not currently working; he was planning to become a dentist but did not finish his university exams because of financial problems. He was later imprisoned for robbery for five years. Before displacement his family was well off. His mother's grave is in South Ossetia but he can

no longer visit it because of the 2008 war. Shota is 55 years old, from Abkhazia, and lives with his wife, two daughters, and two grandchildren. He built the cottage his family lives in. He is a war veteran and disabled. After displacement in 1993 he lived with his family in a compact settlement in Batumi, a city in southwestern Georgia. He came to Tbilisi in 2000.

Appendix H. Interview Guides

Please Note: Only the English versions of interview forms and guides have been included here. Georgian versions are available upon request from the author. Interview guides were developed iteratively so only one version per study is provided as an example.

Study 1 Key Informant Interview Guide

GEORGIA PRM STUDY: Key Informant Questionnaire for Tbilisi

Interviewer ID #: _____		Interviewer _____	
Region:		Settlement:	
Male / Female	Age:	Profession:	
Employment/ Connection with IDPs:			
Position:			
Are you an IDP? 1. No 2. Yes, Wave I 3. Yes, Wave II			

A. Nervousness

1. **QUESTION:** People told us that many older IDPs feel nervous some of the time or often, can you tell us more about this?

PROBES:

- When does this happen?
- When an older person is nervous, what other feelings and thoughts do they have?
- What problems are associated with being nervous?
- How do older people help themselves when they have this problem of being nervous?
- How do other people help them when they have this problem of being nervous?

B. Nothing makes me happy

2. **QUESTION:** People told us that some older IDPs feel like nothing makes them happy, can you tell us more about this?

PROBES:

- a. When does this happen?
- b. When they feel they cannot be happy, what other feelings and thoughts do they have?
- c. What other problems are associated with not being happy?
- d. How do older people help themselves when they have this problem of not being happy?
- e. How do other people help them when they have this problem of not being happy?

C. Feeling abandoned

3. **QUESTION:** People told us that many older IDPs feel abandoned, can you tell us more about this?

PROBES:

- a. When does this happen?
- b. When they quarrel, what other feelings and thoughts do they have?
- c. What other problems are associated with quarreling?
- d. How do older people help themselves when they have quarrels?
- e. How do other people help them when they quarrel?

D. Feeling isolated

4. **QUESTION:** People told us that many older IDPs feel isolated, can you tell us more about this?

PROBES:

- a. When does this happen?
- b. When they feel like they are a burden and cannot help, what other feelings and thoughts do they have?
- c. What other problems are associated with feeling this way?
- d. How do older people help themselves when they feel this way?
- e. How do other people help them when they feel this way?

Study 1 Free List Interview Form

Georgia PRM Study 2010-11

JHSPH/ IPS

Free List Interview Data Collection Form

Interviewer ID #: _____
Location Type: Urban / Rural
Region: _____ City or Town: _____
IDP Status: Recent (2008 or later) / Long-term (prior to 2008)
Male / Female Age: _____ (years)
Marital Status: Unmarried / Married / Widowed / Separated or Divorced

A. What are the major problems that displaced older adults (60 and over) have?

Problem	Brief Description (1-2 phrases)
1. _____	_____ _____
2. _____	_____ _____
3. _____	_____ _____
4. _____	_____ _____
5. _____	_____ _____
6. _____	_____ _____
7. _____	_____ _____
8. _____	_____ _____
9. _____	_____ _____
10. _____	_____ _____

B. What are the major problems displaced older adults have that affect their families?

1. _____

2. _____

3. _____

4. _____

5. _____

6. _____

7. _____

8. _____

9. _____

10. _____

C. What routine tasks do displaced older adults do to take care of themselves?

1. _____

2. _____

3. _____

4. _____

5. _____

6. _____

7. _____

8. _____

9. _____

10. _____

D. What routine tasks do displaced older adults do to take care of their families?

1. _____

2. _____

3. _____

4. _____

5. _____

6. _____

7. _____

8. _____

9. _____

10. _____

E. What routine tasks do displaced older adults do to participate in the community?

1. _____

2. _____

3. _____

4. _____

5. _____

6. _____

7. _____

8. _____

9. _____

10. _____

F. Who can you recommend in this community who knows more about these problems?

Studies 2 and 3 Key Informant Interview Guide

Principal Investigator (PhD Thesis advisor): Peter J. Winch, IH/SBI

Student investigator (PhD thesis research): Namrita S. Singh, IH/SBI

Study Title: Patterns of care and management of mental illness among the protracted internally displaced population in the Republic of Georgia

IRB No.:

IRB00002976

PI Version Number/Date:

Version 1 / 07 August 2010

KEY INFORMANT INTERVIEW GUIDE

1: INTRODUCTION

1. Tell me about your job here
2. How did you come to work here?
3. What kinds of *[research do you carry out/ services do you provide/ policies do you implement]* that benefit IDPs?

2: MENTAL HEALTH ISSUES

1. What are the biggest mental health problems in Georgia?
 - a. What causes those problems?
 - b. What is being done to address those problems?
2. What is your evaluation of the mental health of IDPs?
3. What are IDPs' biggest mental health problems?
 - a. What causes those problems?
 - b. What is being done to address these problems?

3: SERVICES FOR IDPS

1. What mental health or psychosocial services are available for IDPs? The general population?
2. What other organizations here help IDPs?
3. How well are these services used by IDPs?
4. What are the barriers to use?
5. Is there any service that most IDPs use to address psychological problems?
6. What other kinds of mental health services are needed for IDPs?
7. How often do IDPs go to general practitioners for mental health problems?

4: INFORMAL CARE SECTOR

8. How is mental illness addressed within families?
9. What kinds of advice or remedies do friends and family suggest for treating mental illness?
10. Do people with psychological problems tell their friends and families about their problems? How does this happen?
11. What is the role of family and friends in helping IDPs with psychological problems or mental illness?
12. What other kinds of non-medical services do IDPs use to address mental illness?

5: CONCLUSION

1. Is there anything else you wanted to tell me or talk about?

Thank you.

Study 2 IDP Interview Guide

Principal Investigator (PhD Thesis advisor): Peter J. Winch, IH/SBI

Student investigator (PhD thesis research): Namrita S. Singh, IH/SBI

Study Title: Patterns of care and management of mental illness among the protracted internally displaced population in the Republic of Georgia

IRB No.:

IRB00002976

PI Version Number/Date:

Version 1 / July 25, 2012

IDP INTERVIEW GUIDE

I. PERSONAL BACKGROUND

1. Please tell me about yourself
 - Probes:
 - How old are you?
 - Who do you live with?
 - What do you do every day?
 - How long have you been living here?

II. LIVING IN THE COMMUNITY

2. What is it like to live here?
 - Probes:
 - Tell me about being a part of this community
 - What does it mean to belong to a community? Which communities do you belong to?
 - What is it like to live in this community as an IDP?
 - Tell me about your interactions with IDPs and with non-IDPs
 - What is it like to live in this building?
 - Describe the places in this building and in your community where you socialize

III. SOCIAL SUPPORT

3. Please tell me about the people in your life
 - Probes:
 - Tell me about your family and friends—who are they?
 - Tell me about how you make friends. What about when you first arrived here?
 - Tell me about the people you go to when you have a problem
 - How do you decide who to go to and when to go to them?
 - Who comes to you for support?
 - How supported do you feel?

IV. EVALUATIONS

4. What do you think about the programs available for IDPs?
 - Probes:
 - Where do you receive assistance from? What services do you use in your community?
 - Tell me about programs that help with social and psychological problems that IDPs have
 - What do you think about government policy and programs on integrating IDPs into communities?
 - What is your hope for the future?

V. REACTIONS TO EARLIER FINDINGS

5. In earlier research with IDPs last year, people told us what happens when they have psychological problems and what they do to solve those problems. We are interested in hearing what you think about what we discovered after talking to them. We will read you several statements that summarize what we discovered and then ask for your reactions after each.

(After each statement, ask: What do you think about this?)

- A. It is common to feel sadness or depression and to have problems with nerves or to feel nervousness. It is also common to have problems with aggression or anger. It is fairly common to have trouble sleeping. It is not very common to have schizophrenia or psychosis.
- B. Apekti is a psychological problem where a person temporarily loses control of his/herself. Batonebi can mean either an infectious disease or a psychological problem where a person has psychosis or is possessed by spirits.
- C. It is not common to see a psychologist or a psychiatrist if someone has a psychological problem. Most people only see psychiatrists if they have a serious mental illness like schizophrenia. Many people don't know where to go to see a psychologist or psychiatrist and don't have money to pay for it. However, if people knew more about psychologists, and if psychologists were more available, maybe more people would go. Psychologists have the potential to help IDPs with their problems.
- D. Talking to priests and going to church or praying is helpful when someone has a psychological problem. Priests know how to help people get through difficult times and they understand people's problems. Religion is one of the best ways to deal with personal problems.
- E. If someone has a psychological problem, it is most common to talk to friends and family. Friends and family are the best place to go to for support because they know how to help and they can look after people all the time.

VI. WRAP-UP

6. Is there anything else you want to tell me or talk about?

Thank you.

Study 3 IDP Interview Guide

Principal Investigator (PhD Thesis advisor): Peter J. Winch, IH/SBI

Student investigator (PhD thesis research): Namrita S. Singh, IH/SBI

Study Title: Patterns of care and management of mental illness among the protracted internally displaced population in the Republic of Georgia

IRB No.:

IRB00002976

PI Version Number/Date:

Version 1 / 29 July 2010

IDP INTERVIEW GUIDE

DAY 1.

1: INTRODUCTION

4. What was your age at your last birthday?
5. What language(s) do you speak?
6. What ethnic group are you part of?
7. How long have you lived in this collective center?
8. Tell me about your family
9. Tell me about the kind of work you do
10. What is it like to live in the collective center?
11. Can you describe your experiences with non-IDPs?
12. How is your health?

2: MIGRATION HISTORY

13. Tell me about how you came to Zugdidi
14. How did you feel when you left your home?
15. How did you feel when you came here? How do you feel about living here now?

3: CONCEPTIONS OF MENTAL HEALTH AND SYMPTOM RECOGNITION

1. Describe what a healthy person is in your opinion
2. How do you know if someone is not healthy?
3. What does it mean to have psychological problems?
4. Describe what a person with mental illness is like
5. How do you know when you are feeling distressed?
6. How do you know when other people are feeling distressed?
7. Do other people help you to recognize if you are feeling distressed or have a psychological problem?
8. When someone has a psychological problem, is that person able to do daily tasks?

4: PERCEIVED NEED AND SOCIAL COMPARISONS OF DISTRESS

1. Tell me about what it's like to experience distress
2. Describe a time when you felt particularly distressed
3. How often do you feel this way?
4. Do you feel healthy?
5. How healthy do you feel compared to your family and friends? Other IDPs?
6. Tell me about your family and friends and how they experience distress
7. What do people here think about someone who experiences distress or psychological problems?

8. What do people here think about someone with mental illness?
9. Have you ever seen someone being teased or treated badly because the person had a psychological problem?

DAY 2.

5: CARE-SEEKING DECISION-MAKING

1. Earlier you described a time when you felt particularly distressed. When did you realize that you were feeling this way?
2. How did this problem affect you?
3. How did you realize that this was a problem that you needed to address?
4. How did you come to the decision to address this problem?
5. What barriers made it difficult for you to decide to address this problem?
6. Did you talk to other people about this problem?
7. What made you want to address this problem? In what ways would addressing the problem help you?

6: ROLE OF HOUSEHOLD AND SOCIAL SUPPORT SYSTEMS

1. Tell me about the people in your family and others who are close to you
2. Who do you spend time with on a regular basis?
3. When you have any kind of problem, who do you go to for help?
4. What kind of help or advice do you provide your family and friends?
5. How important is it to share problems with your family and friends?
6. What kinds of problems can your family help you with?
7. What kinds of problems can your friends help you with?
8. When you go to your family and friends for help with a psychological problem, what kinds of advice do they give you?

7: CARE-SEEKING PATHWAYS AND MANAGEMENT PATTERNS

1. Let's return to the problem you were talking about earlier. Tell me all the things you thought about doing to address this problem.
2. What was the first thing you did to address the problem?
3. What else did you do or did you want to do?
4. What are you doing right now?
5. Was it difficult to do these things?
6. When you decided to address the problem, were there delays in you doing so?
7. Who among your friends and family did you talk to?
8. Did you talk to anyone else?
9. How many times did you talk to your family/friends? How many times did you talk to others?
10. What can a doctor do to treat distress? Did you ever visit a doctor?
11. What can a priest or the church do to treat distress? Did you ever visit a church?
12. How does what you eat or drink affect distress?
13. What else do people here do when they have psychological problems?
14. What do people do when they have mental illnesses?
15. What did you expect would happen when you *[talked to others/saw a doctor/went to church/etc.]*?
16. How did *[talking to others/visiting a doctor/going to church/etc.]* help you?
17. What do you think about mental health care? Psychologists? Social workers?

8: EXPERIENCES OF FORMAL MENTAL HEALTH SERVICES

[For those participants who have received formal mental health services]

1. Tell me about your experience when you received mental health treatment

9: CLOSING

1. Is there anything that we have not discussed that you would like to share with us?
2. Do you have any remaining questions?

Thank you.

CURRICULUM VITAE:

NAMRITA SHIRIN SINGH

Johns Hopkins University Bloomberg School of Public Health
Department of International Health, Social and Behavioral Interventions Program
Rm. E5031, 615 N. Wolfe Street, Baltimore MD 21205, USA
nasingh@jhsph.edu | 1-443-996-3845

EDUCATION

Doctor of Philosophy (PhD), International Health, Social and Behavioral Interventions Defended in Dec. 2013
Johns Hopkins Bloomberg School of Public Health, Baltimore, MD, USA
Dissertation: *Mental health care spaces, trajectories, and social integration among internally displaced persons in Georgia*

Certificate in Public Mental Health Feb. 2012
Johns Hopkins Bloomberg School of Public Health

Master of Science (MSc), Forced Migration July 2007
University of Oxford, Refugee Studies Centre, Oxford, UK
Thesis: *Psychosocial Approaches and 'Well-Being' in Post-conflict Humanitarian Programmes: The Case of Afghanistan*

Bachelor of Arts (BA), magna cum laude, Phi Beta Kappa, Distinction in Psychology May 2005
Colorado College, Colorado Springs, CO, USA
Minor in Russian and Eurasian Studies
Thesis: *Attitudes Towards Depressive Disorder and its Treatment: A Cross-Cultural Comparison between IDP and Student Populations in Azerbaijan and the United States*

ADDITIONAL TRAINING

Rapid Psychological First Aid Certification April 2013
Johns Hopkins Preparedness and Emergency Response Learning Center

Advanced-Low Russian Language Oral Proficiency Certification Sep. 2011
American Council on the Teaching of Foreign Languages

Advanced Russian Language Certification Mar.-May 2004
Colorado College Russia Study Abroad Program: the Maxim Gorky Literary Institute, Moscow and the Nevsky Institute of Language and Culture, Saint Petersburg, Russia

PUBLIC HEALTH RESEARCH EXPERIENCE

Research Associate Oct. 2011-Present
Behavioral Health Leadership Institute, Project Connections Community Psychiatry Program, Baltimore, MD, USA

- Independently designed a longitudinal qualitative evaluation of a buprenorphine induction and community mental health program. Independently wrote and was awarded a JHU Urban Health Institute grant for this evaluation.
- Developed a client perceived value of services survey instrument for a community psychiatry program providing mental health services to people living in underserved communities in Baltimore

- Pilot tested the instrument and analyzed client evaluation data using STATA
- Preparing a field manual and technical report outlining the instrument development process

NIH Pre-doctoral Fellow and Student Investigator

Sep. 2010-Jan. 2014

Johns Hopkins Bloomberg School of Public Health

Qualitative Study on “Mental health care spaces, trajectories, and social integration among internally displaced persons in the Republic of Georgia”

- Designed research protocol and materials and independently led data collection and analysis in Georgia
- Trained and supervised research assistants in qualitative methods, interviewing techniques, and research ethics
- Conducted in-depth interviews with IDPs and key informants, as well as site visits to state mental health service sites and psychosocial program sites

Field Coordinator/Research Assistant

Aug. 2010-Jan. 2014

Johns Hopkins Center for Refugee and Disaster Response, Baltimore, MD, USA

Mixed Methods Prevalence Study on “Aging in Displacement: Assessing Health Status of Displaced Older Adults in the Republic of Georgia,” funded by the US Bureau of Population, Refugees and Migration (BPRM)

- Trained a team of field interviewers in qualitative research methods, interviewing techniques, and research ethics
- Coordinated field procedures and supervised data collection, cleaning, and analysis
- Worked with local teams to conduct in-depth and free-list interviews with Georgian IDPs in collective centers and settlements and Chechen refugees
- Contributed to the development and adaptation of a household survey instrument derived from the qualitative data
- Analyzed qualitative data and wrote on results for donor reports and scholarly manuscripts; presented findings to BPRM, JHSPH, and Georgian audiences

Graduate Research Assistant

Sep. 2008-May 2010

Johns Hopkins Bloomberg School of Public Health

- Drafted manuscripts and assisted with other tasks as necessary, including literature searches, editing manuscripts, and preparing grants

Qualitative Data Analyst Consultant

Oct. 2009-Nov. 2009

PATH/ USAID Infant and Young Child Nutrition (IYCN) Project in Zambia

- Coded and analyzed focus group transcripts on maternal nutrition practices
- Generated a codebook and wrote a technical report presenting findings and programmatic recommendations

Student Investigator for Qualitative Study on Older Adult Georgian IDPs

May 2009-Sep. 2009

Johns Hopkins Centers for Refugee and Disaster Response and Global Health

- Developed a study protocol and interview schedule for a study on the health needs of older adult Georgian IDPs
- Trained field interviewers in qualitative research methods and interviewing techniques
- Worked with local field staff to conduct key informant and free-list interviews with older adult IDPs

TEACHING EXPERIENCE

Associate Faculty

Jan. 2014

Johns Hopkins Bloomberg School of Public Health

Course: *Global Health Principles and Practices*

Jan. 2014-May 2014

(Co-Instructor)

Course: *Mental Health Intervention Programming in Low and Middle Income Countries*

Jan. 2014-Mar. 2014

(Co-Instructor)

Lecturer Jan. 2013-Mar.2013
 Johns Hopkins Bloomberg School of Public Health
 Course: *Intervention Programming for Mental Health Research in Low and Middle Income Countries*

- Co-designed and co-taught graduate level seminar for master's and doctoral students at Johns Hopkins Medical Institutions on global mental health interventions
- Instructed eight out of fifteen sessions on research and program design, evaluation, cross-cultural mental health and evidence based practices
- Advised and evaluated students on course topics and assignments

Operations Research Trainer/ Consultant Aug. 2013 – Sept. 2013
 Catholic Relief Services

- Designed training modules for an operations research workshop
- Trained in-country program teams in research design and methods, including qualitative methods
- Mentored in-country program teams in research proposal development and reviewed proposals

Guest Lecturer Sept. 2009-Present
 Johns Hopkins Bloomberg School of Public Health

- Qualitative Data Analysis (5/8/2013)
- Ethnographic Fieldwork (2/13/2012)
- Social and Behavioral Interventions Program Seminar III: Intervention Case Studies (1/24/2011; 3/12/2012)
- Formative Research for Behavioral and Community Interventions (5/17/2010)

Teaching Assistant
 Johns Hopkins Bloomberg School of Public Health

Course: *Formative Research for Behavioral and Community Interventions* Mar. 2010-May 2010

- Evaluated student performance on a term paper throughout the course
- Provided guidance and feedback on the term paper and course content
- Taught a class on 'Mixed Methods in Formative Research and Free-listing'

Course: *Health Behavior Change at the Individual, Household, and Community Levels* Nov. 2009-Dec. 2009

- Evaluated student performance on two papers and a final project
- Provided guidance and feedback on the course content and assignments
- Led regular discussion groups for a section of 25 students

Seminar Coordinator Sept. 2009-Dec.2009
 Johns Hopkins Bloomberg School of Public Health

Course: Research and Ethics Seminar on Mental Health and Displacement

- Initiated a student-led seminar with two other students
- Developed an eight session curriculum on displacement and mental health issues
- Led selected course sessions and participated in seminar

OTHER RESEARCH EXPERIENCE

Research Intern June 2012-Dec. 2012
 Brookings-LSE Project on Internal Displacement, Brookings Institution, Washington D.C., USA

- Prepared a critical literature review on non-camp IDPs and the role of municipal authorities for co-director Elizabeth Ferris

Research Intern Feb. 2008-June 2008
 Institute of Social Studies Trust (ISST), New Delhi, India

- Conducted preliminary research on working conditions of Burmese refugees in West Delhi and developed a qualitative research protocol and interview schedule

- Assisted with field research in Delhi slums and government program evaluations in Himachal Pradesh
- Conducted desk research on patterns of cross-border migration into Delhi

Student Researcher

Oct. 2006-Mar. 2007

Refugee Studies Centre, University of Oxford

- Collaborated with a local non-profit organization on an evaluation of a psychosocial program for detained asylum seekers
- Developed focus group and interview guides and collected data from detained asylum seekers, representatives of the UK Home office, organization volunteers, and immigration lawyers
- Trained peer researchers in focus group discussion moderation techniques

Institutional Research Coordinator

Aug. 2005-Aug. 2006

Colorado College Office of Institutional Research

- Analyzed data from internal campus surveys and national data from the Higher Education Data Sharing (HEDS) consortium, Common Dataset, and other national datasets using SPSS
- Moderated focus groups and analyzed data for departmental reviews and college reports
- Performed general administrative duties, including maintaining office web pages, tracking office expenses, supervising work-study students, and handling confidential data

ADDITIONAL EXPERIENCE

Odissi Indian Classical Principal Dancer, Teacher, and Workshop Leader

1997-2006

Nataraj Dance Company, Amherst, MA, USA

- Trained for seventeen years in Odissi dance
- Performed widely as a principal dancer across New England and Colorado
- Taught private and group Odissi dance classes to children, adolescents, and adults in Massachusetts and Colorado

PROFESSIONAL DEVELOPMENT

Languages: English (Native), Russian (Advanced), Georgian (Beginner), Hindi (Beginner)

Computer Skills: STATA, SPSS, Mplus, Anthropic, UCINET, Epi Info, Atlas.ti, NVivo, SmartDraw

Professional Societies: Association for Psychological Science, American Public Health Association, Society for Applied Anthropology, International Association for the Study of Forced Migration, International Society for Traumatic Stress Studies

Professional Service: Student coordinator for the JHSPH Global Mental Health Collaborative Group; Creator of Women and Work Discussion Group

Volunteer Work: Mentor for Colorado Springs Lutheran Family Services: Refugee and Asylee Program (2005-2006);

Volunteer for Lutheran Social Services of New England: Refugee Resettlement Agency (2002)

AWARDS AND DISTINCTIONS

National Awards

NIH Ruth L. Kirschstein National Research Service Award, Individual Predoctoral Fellowship	2011-14
Fulbright Research Fellowship	2010-11
National Security Education Program (NSEP) David L. Boren Fellowship (Awarded in 2009)	2010-11
Rotary International Ambassadorial Academic-Year Scholarship	2006-07
Mortar Board National College Senior Honor Society Rosemary Ginn Fellowship	2006-07

Institutional Awards

Johns Hopkins Urban Health Institute Small Grants Program Recipient	2013
Johns Hopkins School of Public Health Humanitarian Assistance Fund Scholarship	2010
Johns Hopkins Center for Global Health Fogarty Framework Award	2009
Johns Hopkins School of Public Health Baker, Reinke, and Taylor Scholarship	2009
Colorado College Outstanding Commitment to Social Change Award	2005
Colorado College Cornelia Manley Sabine Award in Psychology	2005
Colorado College William Arthur Blakely Memorial Award in Psychology	2004
Colorado College Margaret T. Barnes Science (Merit) Scholarship	2001-05
Colorado College Women's Educational Society (WES) Scholarship	2001-05
Colorado College Dean's List	2002-05

National Honor Societies

Phi Beta Kappa National Academic Honor Society
Psi Chi National Honor Society in Psychology
Phi Sigma Iota International Honor Society in Foreign Language Study
Mortar Board National College Senior Honor Society
Blue Key Honor Society

PUBLICATIONS

1. Murray, L.K., **Singh, N.S.**, Surkan, P., Semrau, K., and Bass, J. (2012) 'A qualitative study of Georgian youth who are on the street or institutionalized.' *International Journal of Pediatrics*, Article ID 921604, 11 pages.
2. Surkan, P.J., Mullaney, L.C., **Singh, N.S.**, and Beyrer, C. (2012). 'Approaches to the development of human rights indicators for women's health.' *Health and Human Rights, Perspectives Piece*.
3. **Johns Hopkins Center for Refugee and Disaster Response (2012)**. "Aging in Displacement: Assessing Health Status of Displaced Older Adults in the Republic of Georgia," US Department of State, Bureau of Population, Refugees and Migration. [**First author** of 'Chapter 3: Qualitative Study']
4. Erdal, K., **Singh, N.**, and Tardif, A. (2011) 'Attitudes about depression and its treatment among mental health professionals, lay persons and immigrants and refugees in Norway.' *Journal of Affective Disorders*, 133(3): 481-88.
5. **Singh, N.** and Robinson, C. 'Social support systems among urban IDPs in Georgia,' *Forced Migration Review*, 34: Issue on Urban Displacement, February 2010.

PUBLICATIONS UNDER REVIEW

1. **Singh, N.S.**, Jakhaia, N., Amonashvili, N. and Winch, P.J. (2013). 'Reaching Recovery: Narratives of Mental Health Care-Seeking Among Long-Term Internally Displaced Persons in the Republic of Georgia.' *Journal of Transcultural Psychiatry*. Under Review.
2. Mannan, I., **Singh, N.S.**, Ali, N.A., Sania, A., Krishna Das, M., Arifeen, S.E., Baqui, A.H., Winch, P.J. and the Bangladesh PROJAHNMO Study Group. 'Community health workers in a household context: Case study from Sylhet District, Bangladesh.' *Health Care for Women International*. Under Review.

SELECTED PRESENTATIONS

1. **Singh, N.** "Mental Health Care-Seeking and Connectedness Among Long-Term Internally Displaced Persons in the Republic of Georgia." Accepted to panel on *Social Ties, Social Bonds and Community Resilience: The Importance of Relationships in Post-Trauma Mental Health in Low Resource Communities*. Presented at the *International Society for Traumatic Stress Studies 29th Annual Meeting*, Philadelphia, U.S.A, November 7-9, 2013.

2. **Singh, N. (Chair)** “Challenges in measurement and service delivery for mental illness among long-term internally displaced persons in the Republic of Georgia” in panel on “Mental health consequences of conflict and displacement: Research challenges and service needs.” Presented at the *World Association for Social Psychiatry 21st World Congress*, Lisbon, Portugal, June 29 – July 3, 2013.
3. **Singh, N.** ‘Constructing care-seeking spaces and pathways: identity, integration, and mental illness experiences among protracted internally displaced persons in Georgia.’ Presented at the *Psy-ences and Mental Health in East Central Europe and Eurasia* conference, University of Chicago, Chicago, U.S.A., April 29-30, 2013.
4. **Singh, N.** ‘Reaching Connectedness: Proposing a model of local integration and care-seeking strategy—the case of protracted internal displacement in the Republic of Georgia.’ Presented at the *14th Conference of the International Association for Studies in Forced Migration (IASFM), “Contested Spaces and Cartographic Challenges,”* Mahanirban Calcutta Research Group, Kolkata, India, January 6-9, 2013.
5. **Singh, N.** “I Expressed My Anger With All Emotions”: Positioning Experiences And Expressions of Anger Among IDPs in Georgia. Presented at the ‘*War and Peace: Power and Representation of Men and Women Conference,*’ Tbilisi State University Center for Social Studies, Tbilisi, Georgia, December 6, 2012.
6. Robinson, C., **Singh, N.**, Perrin, P., Sumbadze, N., Bass, J., Rebok, G.W. ‘Aging in Displacement: Assessing Health Status of Displaced Older Adults in the Republic of Georgia.’ Results presentation, U.S. State Department Bureau of Population, Refugees, and Migration, Washington D.C., USA, May 4, 2012.
7. **Singh, N.** ‘Mental Health Needs and Care-Seeking for Mental Illness Among Urban, Protracted IDPs in Georgia.’ Presented at the *Psycho-Social Services and Training Institute in Cairo (PSTIC) Conference on “A Growing Challenge: Psychosocial and Mental Health Support for Refugees and Migrants Living in Urban Settings.”* PSTIC, American University in Cairo Center for Migration and Refugee Studies, Cairo, Egypt, April 11, 2012.
8. **Singh, N.** ‘Care-Seeking for Mental Illness and Local Integration Among Protracted IDPs in Georgia.’ Presented at the *72nd Society for Applied Anthropology Annual Meeting*, Baltimore, USA, March 28, 2012.
9. Robinson, C., **Singh, N.**, Perrin, P., Sumbadze, N., Bass, J., Rebok, G.W. ‘Aging in Displacement: Assessing Health Status of Displaced Older Adults in the Republic of Georgia.’ Presented at the *139th American Public Health Association Annual Meeting in the Aging & Public Health session*, Washington D.C., USA, October 31, 2011.
10. **Singh, N.** ‘Care and Management of Mental Illness Among the Internally Displaced Population in Georgia.’ Presented at the *International Conference on Living in Displacement: Prospects for Change?* Tbilisi State University Center for Social Sciences, sponsored by the University of Arizona, Rutgers University, and the Institute for Policy Studies, funded by the National Science Foundation, Tbilisi, Georgia, March 15, 2011.
11. **Singh, N.** ‘An institutional analysis of psychosocial approaches in post-conflict humanitarian programmes: The case of Afghanistan.’ Presented at the *Center for Research on Nationalism, Ethnicity and Multiculturalism (CRONEM) 6th Annual Conference*, University of Surrey, Guildford, UK, June 29-30, 2010.
12. Erdal, K., **Singh, N.**, Tardif, A. ‘Cross-cultural conceptualization of depression and its treatment.’ Presented in poster session at the *Association for Psychological Science 22nd Annual Convention*, Boston, USA, May 28, 2010.